

North West London Acute Provider Collaborative Board in Common - Public

18 October 2022

09:00 GMT+1 Europe/London

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1. Welcome and Apologies for Absence

Standing item Speaker: Chair in Common, Matthew Swindells Time: 09.00

References:

- Enc 0. NWL BiC Public Agenda Final 18.10.22.pdf

North West London Acute Provider Collaborative Board in Common - Public

Tuesday 18 October 2022, 9.00am – 11.30am

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

Members of the public are welcome to join this meeting via Microsoft Teams via the following link:- [Here](#)

The Chair will invite question at the end of the meeting. It would help us to provide a full answer if you could forward your questions in advance to lnwh-tr.trustsecretary@nhs.net but this is not a requirement, you can ask new questions on the day. Any questions that are submitted in writing but due to time are not addressed in the meeting, will be answered in writing on the Acute Provider Collaborative's website.

A G E N D A

Time	Item No.	Title of Agenda Item	Lead	Enc
09.00	1.0	Welcome and Apologies for Absence	Chair in Common, Matthew Swindells	Verbal
09.05	1.1	Declarations of Interest	Chair in Common, Matthew Swindells	Verbal
09.08	1.2	Minutes of the Previous Provider Board Meetings held in July 2022 <ul style="list-style-type: none"> Chelsea and Westminster Hospital NHS Foundation Trust Imperial College Healthcare NHS Trust London North West University Healthcare NHS Trust The Hillingdon Hospitals NHS Foundation Trust 	Chair in Common, Matthew Swindells	Enc 1
09.10	1.3	Patient/Staff/Stakeholder Story	Councillor Ketan Sheth / Carolyn Downs	Verbal
Delivery and Assurance				
09.20	2.0	Report from the Chair in Common <ul style="list-style-type: none"> North West London Acute Provider Collaborative Statement of Intent 	Chair in Common, Matthew Swindells	Enc 2
09.30	2.1	Chief Executive Officers' Reports <ul style="list-style-type: none"> Chelsea and Westminster Hospital NHS Foundation Trust Imperial College Healthcare NHS Trust 	Chief Executive Officers, Lesley Watts, Patricia	Enc 3

		<ul style="list-style-type: none"> London North West University Healthcare NHS Trust The Hillingdon Hospitals NHS Foundation Trust 	Wright, Tim Orchard, Pippa Nightingale	
Decision Making and Approvals				
0950	3.0	NWL Acute Provider Collaborative Scheme of Delegation	David Searle/Peter Jenkinson, Directors of Corporate Governance	Enc 4
1000	3.1	Terms of Reference: <ul style="list-style-type: none"> Board in Common Collaborative Quality Committee Collaborative Finance and Performance Committee Collaborative People Committee Collaborative Infrastructure and Capital Committee Collaborative Nomination and Remuneration Committee 	David Searle/Peter Jenkinson, Directors of Corporate Governance	Enc 5
Integrated Performance, Quality and Workforce				
1005	4.0	<ul style="list-style-type: none"> Integrated Performance, Quality and Workforce Report 	CEO Workstream Leads	Enc 6
10.15	4.1	<ul style="list-style-type: none"> Report from Collaborative Finance and Performance Committee Chair Month 5 Financial Report 	Committee Chair and CEO Lead Catherine Jervis / Lesley Watts	Enc 7
10.25	4.2	<ul style="list-style-type: none"> Report from Collaborative Quality Committee Chair 	Committee Chair and CEO Lead Steve Gill / Tim Orchard	Enc 8
10.35	4.3	<ul style="list-style-type: none"> Report from Collaborative People Committee Chair 	Committee Chair and CEO Lead, Janet Rubin /Pippa Nightingale	Enc 9
10.45	4.4	<ul style="list-style-type: none"> Report from Collaborative Infrastructure and Capital Committee Chair 	Committee Chair and CEO Lead Bob Alexander / Patricia Wright	Enc 10
Strategy and Operational Planning				
10.50	5.0	Winter Plan 2022/23	Claire Hook	Enc 11
Governance and Risk				

11.05	6.0	<p>Reports from Trust Audit Committees</p> <ul style="list-style-type: none"> • The Hillingdon Hospitals NHS Foundation Trust • Chelsea and Westminster Hospital NHS Foundation Trust • Imperial College Healthcare NHS Trust 	Audit Chairs	Enc 12
Reports for Information Only				
		Nil		
Any Other Business				
11.20	7.0	Nil Advised		
Questions from Members of the Public				
11.20	8.0	The Chair will initially take one question per person and come back to people who have more than one question when everyone has had a chance, if time allows.		
Close of the Meeting				
11.30				
Date and Time of the Next Meeting				
17 January 2023 at 9.00am				
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

Standing item Speaker: Chair in Common, Matthew Swindells Time: 09.05

1.2 Minutes of the Previous Provider Board Meetings held in July 2022

Discussion Item Speaker: Chair in Common, Matthew Swindells Time: 09.08

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

References:

- Enc 01 a. CWFT Draft Public Board Minutes 07.07.22.pdf
- Enc 01 b. ICHT Trust Board Minutes (Public) - 20 July 2022 - FINAL Minutes SH PJ MS.pdf
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Minutes of the Board of Directors (Public Session)

Held at 11.00am on 7 July 2022 on MS Teams

Present	Matthew Swindells	North West London (NWL) Chair in Common	(MS)
	Stephen Gill	Senior Independent Director and Vice Chair	(SG)
	Nick Gash	Non-executive Director	(NG)
	Ajay Mehta	Non-executive Director	(AM)
	Nilkunj Dodhia	Non-executive Director	(ND)
	Lesley Watts	Chief Executive Officer	(LW)
	Roger Chinn	Chief Medical Officer	(RC)
	Rob Hodgkiss	Deputy Chief Executive and Chief Operating Officer	(RH)
	Virginia Massaro	Chief Financial Officer	(VM)
	Robert Bleasdale	Chief Nursing Officer	(RB)
In Attendance	Peter Jenkinson	Interim Director of Corporate Governance	(PJ)
	Daryl Lutchmaya	Interim Deputy Director of Corporate Governance and Trust Secretary	(DL)
	Sue Smith	Interim Director of HR & OD	(SSm)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Martin Lupton	Honorary Non-Executive Director	(ML)
	Dr Nabeela Mughal	Director of Infection Prevention & Control	(NM)
	Emer Delaney	Director of Communications	(ED)
	Chris Chaney	Chief Executive Officer CW+	(CC)
	Claire Davidson	Deputy Director of Midwifery	(CD)
	Victoria Cochrane	Director of Midwifery	(VC)
Amy Dignam	Chair of Maternity Voices Partnership	(ADi)	
Members of the Public/Observers	Anthony Levy	Governor	(AL)
	Minna Korjonen	Governor	(MK)
	Prof Mark Nelson	Governor	(MN)
	Rose Levy	Governor	(RL)
	Dr Des Walsh	Governor	(DW)
	Parvinder Singh Garcha	Governor	(PSG)
	Cllr Will Pascal	Governor	(WP)
	Mariangel Calderon Lopez	Patient	(MCL)
Apologies for Absence	Serena Stirling	Director of Corporate Governance and Compliance	(SS)
	Aman Dalvi	Non-executive Director	(AD)
	Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to the Board	(GA)



Minute Reference		Action
1.0	GENERAL BUSINESS	
1.1	Welcome and Apologies for Absence	
	MS welcomed members of the Board, those in attendance, Governors and members of the public to the Board meeting held in public. Apologies for absence were noted as above.	
1.2	Declarations of Interest including the Board Register of Interest	
	No declarations of interest were received. <u>Resolution:-</u> The Board resolved to approve the Board Register of Interests.	
1.3	Minutes of the Previous Meeting held on 5 May 2022	
	The minutes of the previous Board meeting held in public on 5 May 2022 were agreed as a correct record.	
1.4	Matters Arising and Board Action Log	
	Action 3.1 was closed. The Action Log was approved.	
1.5	Staff Story	
	<p>VC introduced the item. MCL had been admitted to the antenatal ward in September 2021. She recounted her birthing experience.</p> <p>LW stated that the care had not been good enough for this patient and that the purpose of every patient story was for the Trust to learn lessons and to improve in areas not meeting patients' expectations. She went on to say that it would be important to understand the expectations of families of women during the birth experience. Caesarean births could be done in emergencies and also if planned ahead.</p> <p>Action: VC and CD were asked to embed the improvements that were evidently needed to be implemented from the patient story. This would need to be discussed at the Quality Committee and then later at a Public Board meeting.</p> <p>CD explained to the Board that the Trust had implemented an early labour assessment bundle and had agreed funding to increase the ward managers in the inpatient area to support less experienced midwives who had recently qualified. Cases of delays and transference to the labour ward were being flagged at the safety huddles. If women have been waiting for more than six hours to transfer to Labour, then the women would have a senior obstetric to review the situation and discussion re the time frames. The escalation policy would also be updated accordingly. VC added that in the communication and listening was going to be a key learning objective in the next 12-month education programme.</p> <p>In his capacity as the Non-Executive Director responsible for maternity safety and Chair of the Quality committee, SG thanked MCL for sharing her story with the Board and reassured her that the Quality Committee would follow up on the lessons learned and consequent actions.</p>	VC / CD



	<p>The Board thanked MCL.</p> <p><u>Resolution:-</u> The Board resolved to note the patient story.</p>	
1.6	Chair's Report	
	<p>MS updated the Board about the NWL Collaborative that had previously been discussed with all four NWL Acute Trust Boards, the Council of Governors (COGs) at the two Foundation Trusts and with other external stakeholders.</p> <p>The Delegation of Responsibilities paper would be presented to the four NWL Trust Boards in July. The formation of the NWL Collaborative Board in Common would be discussed at a special Chelsea & Westminster Hospital Foundation Trust (CWFT) Board meeting to be held on 22nd July 2022.</p> <p>Further policy and regulatory documents to enact the NWL Collaborative Board in Common would be presented at the four NWL Trust Board meetings and the two Foundation Trust COG meetings, with the intention that all necessary approvals were obtained to enable the NWL Collaborative Board in Common to hold its first meeting in October.</p> <p><u>Resolution:-</u> The Board resolved to note the content of the report.</p>	
1.7	Chief Executive's Report	
	<p>LW stated that the Trust was reinforcing its Infection and Control message and asking staff, patients and visitors to the Trust to continue to wear masks when on site. Mask wearing had not been stood down at the Trust since the previous COVID-19 phase.</p> <p>Performance, activity and elective recovery at the Trust continued to be strong. There had been on going conversations with the ICS, NHS London and with the NHS national team to recognise the activity being achieved and for this to translate into recognised funding.</p> <p>LW and RC had earlier that day launched a research, innovation and quality improvement (RIQI) event that celebrated staff who were not only working, but also testing hypotheses around improvement using research to inform the very best care for patients.</p> <p>The Trust was working hard with its partners in London on urgent and emergency care work. Linked to this, the Integrated Care System (ICS) had come into legal force on 1 July 2022 and the Integrated Care Board (ICB) had been established for NWL.</p> <p>LW reiterated that it was important to still focus on the recruitment and retention of staff and indeed on their health and wellbeing because the happier and more content staff were, the better care they delivered to patients.</p> <p>LW also thanked Eliza H, Non-Executive Director (NED) for her work for the Trust as she had stepped down in June after 8 years.</p>	



	<p>In response to SG’s request for more information about monkey pox in London and the Trust’s response to it, RB informed members that given the size and importance of CWFT’s sexual health service, the Trust had been leading the response to monkey pox. Patients visiting the service were being screened for monkey pox and CWFT was treating 50% of the cases in London and supporting patients in the community at home. The Trust had also established a virtual ward to manage those patients and supporting those patients through their care and treatment. There were 200 patients on the virtual ward and the Trust had started rolling out vaccination at its sites for gay, bisexual and men who had had sex with men who were at the highest risk group. LW added that this had an impact on the ability to run the rest of Sexual Health services and discussions were underway with Commissioners.</p> <p>In reply to AM’s question about enforcing mask wearing, LW said that staff in retail outlets were mandated to wear masks and it was necessary for staff to feel empowered to use the policy to enforce patients and visitors to wear them.</p> <p>ML enquired about what the Trust was doing to avert possible strike action in response to the recently announced pay award.</p> <p>LW replied that the Centre was having these discussions with staff unions and all that the focus of the Trust was to ensure that patients received the best care possible.</p> <p><u>Resolution:-</u> The Board resolved to note the content of the report.</p>	
2.0	FOR DISCUSSION	
2.1	Trust Elective Recovery Plan Update	
	<p>As a system, NWL was doing well compared to the majority of the other systems across the country with reference to elective, non- elective and outpatient activity.</p> <ul style="list-style-type: none"> • The P2 waiting list across NWL had gone up but remained within statistical control limits and just above the average. CWFT was reporting a marginal increase and marginally above the Statistical process control (SPC) average. • Elective Activity had increased from 104.6% to 134.5%. This had been due to planned A&E activity conversion to admissions as per service projections. • High volume low complexity (HVLC) was at 97.1% • Elective Outpatient (OP) 1st was at 103.4% and OP Follow-up had decreased from 108.1% to 81.6%. The reduction in follow-up performance had been due to alignment of reporting rules to NHSE guidance. • As at the 12th June, the Trust Patient tracking list (PTL) had seen an increase in a week from 47,833 to 48,715. 52+ waiters had gone up from 666 patients to 683. The Trust consistently ensured that there were no genuine 104w+ patients on the PTL. 	



	<ul style="list-style-type: none"> • Cancer waiting lists were the highest that they had ever been nationally, but up to the end of May, the Trust’s backlog had reduced and was at 128 patients waiting over 63 days. There were some challenges with histopathology reporting due to the availability of histopathology consultants to do the reporting. Cancer Backlog 63 days+ (w/e 5/6) was at 134, a marginal increase from the previous week. • Endoscopy Activity – 111.0% • Imaging Activity – 95.2% • Echocardiograph Activity – 249.7% to 329.9% -. The service was reporting an activity increase due to extra capacity being put in. <p>The P2 waiting list for the Trust showed that the Trust had the right amount of capacity to treat patients requiring surgery within four weeks. CWFT was doing more activity than it had been doing compared to the same reference period three years prior to COVID-19. The focus would be to continue to treat patients on time and based on clinical priority order.</p> <p>MS asked whether the Elective recovery fund (ERF) baseline changes would be resolved in the near future. RH replied in the affirmative that the baseline adjustments had been agreed.</p> <p>SG provided a short summary about some of the issues that had been discussed at the previous Quality Committee. He stressed that both the Executives and Non-Executives were agreed that patients should be treated in order of clinical priority. RC concurred that patients were always seen in order of need.</p> <p>NG commented on follow-ups and thought that primary care should explain to the patient that they would not always see the consultant who had treated them.</p> <p>RC added that it was similar between Community and Mental Health referrals and was a specific point that the NWL Clinical Advisory Group had been discussing and that it was important to manage patients’ expectations.</p> <p><u>Resolution:-</u> The Board resolved to take assurance of the status of the Elective Recovery plan against planned trajectory.</p>	
<p>2.2</p>	<p>Integrated Performance and Quality Report</p>	
	<p>The report was tabled. It had previously been considered at the Quality Committee, Council of Governors (COG) Quality Committee and at the Executive Management Board (EMB).</p> <p>A&E</p> <p>A&E 4hr performance remained uncompliant with performance of 78.88% in Month 2. This had been the 3rd highest performance in London and 14th highest nationally. Both departments continued to be strong performers with ambulance handover times. The departments remained pressured by increasing type 3 activity, with overall activity in month 6% higher than May 2019. Challenges continued with staffing levels within the Urgent treatment centre (UTC) at West Middlesex with deterioration in the department’s performance impacting performance in A&E.</p>	



	<p><u>Cancer</u></p> <ul style="list-style-type: none"> • 2-Week Wait: This measure was compliant for May 2022. • 28-Day Faster Diagnostic Standard (FDS): The 28-day Faster Diagnosis Standard (FDS) target was marginally non-compliant for May 2022, at 74.79%. The expectation was that following final validation this would achieve compliance. • 62-Day: 62-Day GP Treatment for May 2022 was non-compliant at 65.56%. This was expected to improve as patients treatment status were confirmed but was projected to be non-compliant for the month. Complex patients as well as delays in histology had broadly driven this position, increasing the length of patient’s pathways. • 62-Day Screening: This measure was reporting a non-compliant position currently. This represented 1.5 patient pathways against 1.5 patient breaches. It was noted that this was not a validated position. <p><u>18 Week Referral to treatment time (RTT) Incomplete</u></p> <p>The teams continued to book patients in priority and chronological order to address the longest waiting. Plans to reduce outpatient waits, see patients on different pathways and improve theatre efficiency would result in improved RTT performance. The Trust continued its work to ensure data quality challenges were minimised, the patient tracker lists were accurate and reported performance was as expected.</p> <p><u>Diagnostic Waits <6 weeks</u></p> <p>May performance was marginally below the 99% target. The Trust remained committed to delivering the target with working groups in sub specialities set up to support improvements. May 2022 noted the majority of breaches in Cystoscopy and Echocardiography. Both services had increased capacity in June 2022 by utilising outsourcing provision, it was likely with this resource that breaches in these specialities would be mitigated in June 2022. Endoscopy across the Trust had seen improvements in its breach numbers in May 2022, this reflected the management support in ensuring the booking process was delivered and maintained.</p> <p><u>Resolution:-</u> As there were no questions, the Board resolved to take assurance from the report on the current performance of the organisation.</p>	
<p>2.3</p>	<p>Maternity Services Improvement Programme Report</p>	
	<p>VC attended to present this item. An update was presented about the improvement work in the maternity service, based on the feedback and experiences of service users and included:</p> <ul style="list-style-type: none"> • Survey of women from Black, Asian and minority ethnic (BAME) background experiences of maternity care • Maternity cultural safety and inclusion work • Care quality commission (CQC) maternity survey and action plan • Maternity voices partnership (MVP) overview, successes and work plan <p>An Ethnicity survey was undertaken by the maternity voices partnership (MVP) between August 2020 - Feb 2021 with 373 responses received from</p>	



	<p>service users. Generally, the scores were middle to high satisfaction across all questions.</p> <p>A listening event was held in March 2021 with 16 women in attendance. A detailed action plan was taken through the directorate and division and was monitored via the Trust Patient experience group. A detailed report of the survey was provided to the cultural safety group to inform their improvement plans and actions.</p> <p>The maternity Cultural safety champions group was established in January 2021 and consists of 14 members of the maternity team. The focus of the team was to reduce inequality, improve diversity and inclusion for service users and staff.</p> <p>The third piece of work was around the CQC Maternity survey and women's experiences. The CQC maternity survey sent in November 2021 to all users of maternity services that birthed in the prior February and the results were released in May 2022.</p> <p>ADi presented the work of the Maternity Voices Partnership (MVP), an independent group of service users that advises on all aspects of maternity care. Its role brings together those who use the services and the people who plan and deliver them, in order to bring about improvements and to ensure that the views of parents are taken into account.</p> <p>The Board thanked ADi for her and her team's work.</p> <p>AM enquired about whether the patient story received earlier during the meeting had been to do with a form of race inequality.</p> <p>VC updated the Board that funding had been received to fund posts at providers' sites that would help to reduce inequality and to also backfill Cultural Safety Champions on all sites in NWL.</p>	
	<p><u>Resolution:</u> The Board resolved to note and receive the report and took assurance of the continued work to support Maternity Improvement.</p>	
<p>3.0</p>	<p>FOR APPROVAL</p>	
<p>3.1</p>	<p>Board Business Cycle 2022/23</p>	
	<p>DL updated the Board that the Annual Report and Accounts, the Annual Government Statement and the Board self-certification declarations had been received at the Extraordinary Board on the 16th of June.</p> <p>MS added that a new cycle would be drafted for the NWL Collaborative Board in Common from October onwards.</p> <p>Resolution:- The Board resolved to approve the Board Business Cycle.</p>	



4.0	FOR NOTING – HIGHLIGHTS BY EXCEPTION	
4.1	Learning from Serious Incidents	
	<p>RB presented the item. During the 12-month period ending in May 2022 the Trust reported 161 serious incidents (SIs); 78 External SIs and 93 Internal SIs.</p> <p>In April/May 2022 the Trust declared 10 External SIs (CW 5, WM 5) and commissioned 15 Internal SIs (CW 5, WM 10). A never-event concerning patient identification (wrong site surgery) occurred during this reporting period.</p> <p>There were 10 SI reports approved by the Divisional Serious Incident panel and the Chief Nurse/Medical Director and submitted to the NWL Collaborative (Commissioners).</p> <p>As at the end of June 2022, there were 50 overdue actions. There were 15 strong actions recorded with a criticality score of 5; these actions are absolutely critical to the management and reduction of risk. 14 of these actions had been completed and one action was yet to be closed. The Patient Safety Group oversaw the delivery of SI actions and monitors improvement trajectory on a monthly basis.</p> <p><u>Resolution:-</u> The Board resolved to receive and note the content of the report.</p>	
4.2	Complaints Annual Report	
	<p>RB presented the Annual Patient Advice and Liaison Service (PALS) and Complaints report for financial year 2021-22. During 2021-22, the Trust received a total of 449 complaints which equated to an average of 9 complaints per week. This was an increase of 15% against the number of complaints received during 2020-21 (390).</p> <p>Both RB and LW agreed that there was more work to do in this area.</p> <p>SG summed up saying that there were three key areas where complaints were focussed; clinical treatment, communication and patient care. There was a downward trend at West-mid (WM), but an upward trend at Chelsea (CW). The Quality Committee had discussed this report in detail and would continue to follow up on issues and actions.</p> <p><u>Resolution:</u> The Board resolved to note the content of the report.</p>	
4.3	Infection Prevention and Control Annual Report	
	<p>NM presented the highlights of the report. The Board thanked NM for her leadership and for the outstanding work produced by her team.</p> <p><u>Resolution:-</u> The Board resolved to note and receive the report.</p>	
4.4	People Performance Report	
	<p>SSm drew the Board's attention to the fact that the Trust had an improving vacancy rate and sickness had returned to normal at 3.29% in May 2022. Turnover had continued to rise from 14.39% in April to 14.58% in May and although mobility had returned to pre-pandemic levels, CWFT was slightly higher than the NWL sector position.</p>	



	<p>AM shared his concern that the turnover rate was increasing. Some things were out of the Trust’s control such as retirement, people's health issues, relocation, however he felt that there some things that were in the Trust’s control around flexible working opportunities and training and development which could impact on turnover rates. His main concern however was about patient safety. He stated that if staff were having to cover for one another that it could pose a threat to the level of care that a patient would be receiving.</p> <p>SSm replied that the Workforce Development Committee would be considering a raft of measures to countenance this through terms of retention, exit and retention interviews.</p> <p>SG observed that the whole-time equivalent had been increasing and that the Trust actually had improved safer staffing results.</p> <p>LW added that during bed meetings in the mornings, safe delivery of care to patients was the most important aspect and resources would be deployed to ensure that it happened</p> <p>SG enquired how the Trust was linking the Staff Survey results to the workforce programmes. SSm replied that they were being triangulated with the actions from the People Strategy.</p> <p>ND asked about the ambition metric to recruit more Black, Asian and minority ethnic (BAME) staff above band 8a and what evidence the target was based on.</p> <p>SSm replied that it was based on targets set for the Trust in the NHS London Workforce Race Equality Strategy.</p> <p>Resolution:- The Board noted and received the report.</p>	
<p>4.5</p>	<p>Freedom to Speak Up Report</p>	
	<p>51 concerns had been raised in the 21/22 period, similar to the previous year.</p> <p>MS asked for more information about the five concerns which had been raised regarding racism and staff feeling disadvantaged due to their cultural background.</p> <p>LW and NG believed that it related to one incident and considered that it was due to more people speaking up which had led to the spike.</p> <p>Resolution:- The Board noted and received the report.</p>	
<p>4.6</p>	<p>Learning from Deaths Report Q1 2022/23</p>	
	<p>The Trust was the best performing acute (non-specialist) provider in England in terms of relative risk of mortality for period February 2021 – January 2022. This positive assurance was reflected across the Trust as both sites continued to operate significantly below the expected relative risk of mortality.</p>	



	<p>RC went on to present the report about Hospital Mortality associated with nosocomial transmission of COVID-19 infection which described the learning outcomes from the review of mortality associated in in-hospital transmission of COVID-19 between April 2020 and March 2021.</p> <p>Between 1st April 2020 and 31st March 2021 there were:</p> <ul style="list-style-type: none"> • 183 patients with probable hospital acquired COVID-19 were identified (where a positive result was recorded 8-14 days after hospital admission); of these cases 28 patients sadly died in hospital. • 158 definite hospital acquired COVID-19 cases were identified (where a positive result was recorded 15 or more days after hospital admission); of these cases 35 patients sadly died in hospital. <p>When undertaking retrospective case review of the deaths associated with probable or definite hospital acquired COVID-19 the following outcome avoidability / sub-optimal care conclusions were reached:</p> <ul style="list-style-type: none"> • 36 cases related to frail patients with multiple co-morbidities who would likely have died regardless of acquiring COVID19 • 20 cases related to patients who may have lived had they not caught COVID-19 • 6 cases related to patients who almost definitely would not have died had they not caught COVID-19 <p>Overall, RC felt it was very assuring that staff were adhering to the guidance that had been issued at the time that they were caring for their patients. He went on to confirm in response to ML's question, that as part of the Trust's duty of candour that the families of the patients who had died were spoken with by the Independent Medical Examiner.</p> <p>LW considered the report to be a valuable welcome debrief for staff working at the Trust.</p> <p>Resolution:- The Board noted and received the report.</p>	
<p>4.7</p>	<p>Guardian of Safe Working Report</p>	
	<p>RC presented the report. Its purpose was intended to provide assurance of the safe working hours and working conditions for all junior doctors and dentists employed by the Trust. Senior Trust management and HR had continued to provide support and ensure the safe working of the junior doctor workforce in Q4. A total of 88 exception reports had been submitted during quarter four.</p> <p>Resolution:- The Board noted and received the report.</p>	
<p>5.0</p>	<p>ITEMS FOR INFORMATION</p>	
<p>5.1</p>	<p>Questions from Members of the Public</p>	
	<p>AL asked whether it would be possible to look at hospital acquired COVID-19, which led to mortality after discharge to nursing homes or indeed to a care home. He also asked what actions would be coming out of the report.</p>	



	<p>RC explained that making the link between hospital acquired COVID-19 and those that occurred in the community had not been possible. RC replied that the learning actions were incorporated through the Trust's normal mortality surveillance approach. A review of the learnings from the report would also be adopted and applied.</p> <p>PSG asked whether it would be possible for such reports to be available in other languages so that wider sections of the community could understand. He felt that the Communications Team could do more in this area.</p> <p>ED replied that her team was working with the ICS, Health Watch and local community networks regarding wider communication.</p>	
5.2	Any Other Business	
	<p>SG informed the Board that the Council of Governors (COG) had convened a meeting on 28 June 2022 which included an Agenda item to vote on whether to expel a Governor, the decision to expel the Governor was carried by majority vote.</p>	
5.3	Date of the Next Meeting	
	<p>The next meeting would be held in October, date to be agreed and subject to the necessary approvals per Agenda item 1.6 above would be as part of the NWL Collaborative Board in Common.</p>	

Glossary of Terms

NHS	National Health Service
NHSE/I	NHS England / Improvement
FDS	Faster Diagnosis Standard (Cancer Care)
GIRFT	Getting It Right First Time (An evidence-based quality standard)
MPs	Members of Parliament
ICS	Integrated Care System
NWL	North West London
ITU	Intensive Treatment Unit
P2	Priority 2 Patients (Elective Patients)
IP	In-Patient
DC	Day Case
HVLC	High Volume, Low Complexity
OP	Out Patient
WW	Week wait
BAU	Business as Usual
A&E	Accident and Emergency
RTT	Referral to Treatment Time

Public Trust Board
Minutes of the meeting held on Wednesday 20 July 2022 at 11:00

Virtual meeting held via Microsoft Teams and video-recorded.

Members present

Mr Matthew Swindells	Chair in Common - North West London
Mr Bob Alexander	Vice Chair
Mr Raymond Anakwe	Medical Director
Ms Kay Boycott	Non-Executive Director
Mr Peter Goldsbrough	Non-Executive Director
Ms Claire Hook	Chief Operating Officer
Prof. Tim Orchard	Chief Executive
Prof. Julian Redhead	Medical Director

In attendance

Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Mr Jeremy Butler	Director of Transformation
Mr Kevin Croft	Chief People Officer
Ms Michelle Dixon	Director of Communications
Mr Nick Fox	Commercial Director, Imperial Private Healthcare
Mr Hugh Gostling	Director of Estates and Facilities
Ms Sara Harris	Interim Head of Trust Secretariat (Minutes)
Mr Kevin Jarrod	Chief Information Officer
Mr Peter Jenkinson	Director of Corporate Governance
Dr Bob Klaber	Director of Strategy, Research & Innovation
Ms Shona Maxwell	Chief of Staff
Dr Amrish Mehta	Interim Divisional Director, Women's, Children's and Clinical Support
Ms Saghar Missaghian-Cully	NWL Pathology Managing Director
Dr Matthew Tulley	Director of Redevelopment
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London

Apologies

Prof. Andrew Bush	Non-Executive Director
Ms Beverley Ejimofe	Associate Non-Executive Director
Dr Andreas Raffel	Non-Executive Director
Mr Nick Ross	Non-Executive Director
Ms Sim Scavazza	Non-Executive Director
Prof. Janice Sigsworth	Director of Nursing
Ms Jazz Thind	Chief Financial Officer

Item	Discussion
1.	Opening remarks
1.1.	Matthew Swindells, Chair in Common of the North West London acute trusts, welcomed everyone participating in this virtual meeting.
1.2.	He welcomed Dr Amrish Mehta, Interim Divisional Director of Women's, Children's and Clinical Support to his first Board meeting.

1.3.	Acknowledging the Covid situation, the public meeting was being held virtually and was video-recorded. The Board observed social distancing guidance and therefore limited people participating via Microsoft Teams from different locations.
1.4.	The Board continued to hold the Board meetings virtually, to protect staff, patients and public. National Covid restrictions remain in place in NHS premises, including social distancing and Covid-secure protocols while they remain, Trust Board meetings would continue to be held virtually, however, this would be kept under review.
1.5.	The Chair reminded members of the public that this was a meeting of the Trust Board held in public, but that they would be given an opportunity to ask questions at the end of the meeting. The video of the meeting would be published on the Trust website following the meeting.
2.	Apologies
2.1.	Apologies were noted from those listed above.
3.	Declarations of interests
3.1.	There were no additional declarations to those disclosed on the Trust's register of interests.
4.	Minutes of the meeting held on 25 May 2022
4.1.	The minutes of the previous meeting were approved with the term " <i>internal</i> " to be referenced on page 13; paragraph 22.1.2.
5.	Record of items discussed in part II of the Board meetings held on 25 May 2022 and the Trust Board Seminar held on 14 June 2022.
5.1.	The Board noted the summary of confidential items discussed at the confidential Board meeting held on 25 May 2022 and the Trust Board Seminar held on 14 June 2022.
5.2	The Board noted the update.
6..	Matters arising and actions from previous meetings
6.1.	Updates against the actions arising from previous meetings were noted on the action register.
7.	Chair's report – North West London Acute Trusts
7.1.	Matthew Swindells presented his report and noted terms of office was coming towards an end for three non-executive directors. The Board extended their thanks to: Kay Boycott, Ben Maruthappu and Andreas Raffel for all their support and work during their time serving the Trust.
7.2.	The Board noted the report.
8.	Establish the NWL Acute Provider Collaborative Governance Model
8.1.	Matthew Swindells introduced the proposed governance model for the establishment of the North West London acute provider collaborative and noted that the proposed model had been discussed previously with the four Acute Boards, the Council of Governors at the two Foundation Trusts and with external stakeholders taking into consideration their views. The proposals had also been discussed with NHS England and the CQC.
8.2.	Matthew Swindells commended on the way the four acute Trusts had worked together during the pandemic to serve the people of NWL which clearly demonstrated the benefits of working collaboratively on provision of acute hospital services to the population of North West London. He pointed out to the Board that during that time, services had been moved around in order to support the needs of

	<p>the public and routinely mutual aid was provided from one Trust to another. He also referred to the place based mechanism that was being encouraged by the Integrated Care Board (ICB) and by NHS England (NHSE) which focussed on delivery of local services, and that the Collaborative had clearly demonstrated this.</p>
8.3.	<p>Matthew Swindells introduced Peter Jenkinson, who briefed the Board on the details of the recommendations.</p>
8.4.	<p>The Board considered the proposed meeting structure noting that the first level was the local trust oversight and the proposal was to maintain the same level of local oversight that was currently held through the established board committees. Terms of references for board committees would be amended, however, to standardise and align approach across the four Trusts. The Board considered the proposals for the collaborative level committees and the establishment of a board in common, bringing together the four trust boards to work together under a common agenda. Each Trust would be represented at that level and all four Trusts would be fully represented in any decision making.</p>
8.5.	<p>There was work to do around the practicalities of implementation to define the reporting structure, to ensure accountability at a local level as well as collaboratively.</p>
8.6.	<p>The Board also considered the board membership element of the governance model, including proposals for the non-executive director composition of each of the individual Trust boards.</p>
8.7.	<p>The request to the Board was approval for the delegation of authority for the Trust boards to create the governance model in terms of establishing the board in common. It was noted once formal approval had been granted by the Board, the Trust would need to seek approval from the Department of Health to amend the Trust's Establishment Order, the trust's statutory instrument, in order to establish the proposed board complement.</p>
8.8.	<p>Peter Jenkinson summarised key points:</p> <ul style="list-style-type: none"> ▪ Approval of the governance model. ▪ Scheme of delegated authorities which sets out exactly what decisions can be taken and the different levels. ▪ The structure and how those operated between different levels and the need to develop specific terms of reference for the meetings at the different levels. Those terms of reference would be presented to the first board in common meeting in autumn for formal approval. ▪ Proposal to maintain board committees and would meet again in September 2022 as planned, but in a slightly different form and slightly different membership subject to approval. ▪ Propose to start the collaborative committees in September 2022 and work with each of the individual chief execs and with their respective vice chairs and work out the reporting mechanisms. ▪ The first inaugural board in common meeting to be held on the 18 of October 2022.
8.9.	<p>Bob Alexander concurred that he had conversations with Andy Bush and Nick Ross and both were supportive of the direction of travel and the collaborative arrangements as set out in the report.</p>
8.10.	<p>The Board considered the recommendations as outlined and approved the proposals to create the governance model to support the establishment of the acute collaborative.</p>

9	Chief Executive Officer's report
9.1.	Prof Orchard presented his report to the Board, highlighting key updates on strategy, performance and leadership over the month and the focus of Trust business in response to Covid-19.
9.1.1.	Operational performance – The Trust had experienced a 100% increase in Covid patients in June and July 2022; however, the number of patients being treated in intensive care remained low which was encouraging. Based on this increase, and the prevalence of Covid-19 in the community, the Trust had strengthened some of its infection prevention and control measures again after easing them in early June 2022 in line with national guidance. On the 27 June 2022, the Trust reached the milestone of having cared for over 10,000 Covid-19 positive patients at its hospitals.
9.1.2.	Estates, CBRE - It was noted that during the extreme hot temperatures in London on the 18 and 19 July 2022 when London reached 40 degrees, the Trust's Estates, CBRE and site teams had performed an excellent role in enabling the Trust to respond. The application of solar films around windows and improvements to cooling mechanisms had proved effective and the teams had been quick to respond to whatever issues arose. Special acknowledgement by the Chief Executive was made to: Radek Mysliwek and Rob Davis, at the Hammersmith, Shane King, Mervyn Dukes and Sammy Naji (CBRE) at St Mary's, David Cook at Charing Cross and CBRE Hard FM Partners, for all their hard work.
9.1.3.	Elective Recovery – As of July, the Trust no longer had any patients waiting more than 104 weeks. The focus was now on ending waits of over 78 weeks and at the same time continuing to provide critical care. As of May 2022, the Trust was back to 91% of overall pre-pandemic planned care activity.
9.2.4.	Monkeypox update – The Trust had diagnosed and treated 90 patients with monkeypox. Nationally over 1,000 positive cases had now been identified, the majority of which were in London. Within the capital, north west London had the highest diagnosis rate but the lowest case rate for patients living within the area.
9.2.5.	Covid-19 and flu vaccination programme – The Joint Committee of Vaccinations and Immunisations (JCVI) current view was that in autumn 2022, a Covid-19 vaccine should be offered to: <ul style="list-style-type: none"> ▪ residents in a care home for older adults and staff ▪ frontline health and social care workers ▪ all those 65 years of age and over ▪ adults aged 16 to 64 years who are in a clinical risk group.
9.2.6.	Financial performance – For the first two months of the financial year (April - May 2022), the Trust had reported a £10m deficit and a break even plan had been devised for the financial year 2022/23. The financial plan was underpinned by a level of additional ERF funding for achieving the national target of 104 per cent of cost weighted 2019/20 activity; a level of income to offset the estimated cost of higher than usual inflationary pressure and the delivery of a 3 per cent efficiency programme.
9.2.7.	Maternity assurance – Professor Janice Sigsworth, Chief Nurse, had been appointed the Executive Director champion for maternity from July 2022. A new maternity oversight group had been established which would include representation from across the Trust. This would give additional support and scrutiny of the metrics for maternity care.

- 9.2.8. **Care Quality Commission (CQC) update** – On 21 June 2022, the CQC held an engagement meeting with the leads for Trust cancer services. The CQC was positive about the meeting and did not raise any concerns. On 29 June 2022, the Chair and Corporate governance leads for the four acute Trusts in NWL met with key leads for developing the CQC’s new approach to regulating ICSs and acute NHS providers.
- 9.2.9. **Redevelopment update** – The St Mary’s Hospital strategic outline case submitted in September 2021 had been reviewed by the regional NHSEI team. A date for the formal review with the national New Hospital Programme team was being discussed.
- 9.2.10. **Research update** – The Trust was awaiting formal announcement of the outcome of its reapplication for our National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) for the period 2022-27.
- 9.2.11. **Health and Care Act 2022** – ICHT is a member of the NWL Integrated Care System (ICS) and will, as part of this place based partnership, help bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. ICS became the Integrated Care Board (ICB) on the 1 July 2022.
- 9.2.12. **EDI update** – The quarterly newsletter was launched to support communications, networking and continue to promote our influential staff networks. 40 members of staff marched to Celebrate 50 Years of Pride.
- 9.2.13. **Stakeholder engagement** – Various meetings has been held since the last Board meeting such as working with women’s network, gender equality, issuing a statement on anti-racism. A productive meeting had been held with Cllr Adam Hug, and work was underway with the new administration.
- 9.2.14. **Acute care programme update** – The four acute Trusts in NWL continued to build increasingly effective partnership working arrangements with the urgent need to restore planned care capacity and reduce waits and delays, e.g. ambulance handovers.
- 9.2.15. **Trust annual general meeting/annual report** – The Annual General Meeting (AGM) would be held online via Microsoft Teams on Wednesday 20 July 2022, from 18:00-19:30. The annual accounts and the highlights and challenges of 2021/22, as well as looking forward to the year ahead would also be shared.
- 9.2.16. **Recognition and celebrating success** – The Trust gained bronze accreditation following a recent evaluation of the LGBTQ+ inclusion work with staff and patients. Professor Dame Lesley Regan, consultant at St Mary’s had been appointed as the government’s first ever Women’s Health Ambassador for England.
- Questions from the Non-Executive Directors**
- 9.3.17. Peter Goldsbrough enquired about the impact on Covid on capacity to deliver. Tim Orchard responded the Trust was operating at 100% and there was considerable effort to ensure the cost of delivery against activity. It was noted the Trust could not do all the procedures in outpatient clinics and there was a need to complete analysis to ascertain how that would affect the Trust’s delivery of the operating plan and its financial situation.

<p>9.3.18.</p> <p>9.3.19.</p> <p>9.3.20.</p> <p>9.3.21.</p>	<p>Julian Redhead added in light of the national data, patients with Covid increased their length of stay by at least one day. It also caused operational issues with side rooms and the cohorting of patients and further complications in discharging as well. Overall, the impact on beds around Covid still remained and was still high.</p> <p>Bob Alexander was interested to hear about the operational relations with the other providers in North West London, particularly the Mental Health Collaborative that the Trust was trying to deal with.</p> <p>Tim Orchard explained that one positive impact of Covid had been the development of collaborative relationships with neighbouring providers, in order to maintain services during the pandemic. The task now was to separate what sits in the acute collaborative, and what was within the Trust's gift to influence. Through the acute programme board, the mental health collaborative, the community and primary care would run through the borough based partnerships and those issues were being managed through that process and a priority for the next few months.</p> <p>The Board noted the update.</p>
<p>10.</p> <p>10.1.</p> <p>10.2.</p> <p>10.3.</p>	<p>Patient and Public Involvement</p> <p>Michelle Dixon presented to the Board the 6th annual report on patient and public involvement led by the Chair of the Strategic Lay Forum and Lay Partners. The Forum played a critical role in overseeing the development and the implementation of the Trust's strategy.</p> <p>The Board welcomed Trish Longdon, Chair of the Strategic Lay Forum to the meeting, who shared three videos from:</p> <ul style="list-style-type: none"> ▪ Nafsika Thalassis, former Deputy Chair of the Strategic Lay Forum and Director of the local BME Health Forum, reflected on the importance of working with lay partners and listening to what local communities had to say about their needs and preferences. She focused especially on how local views had led to the creation of a new project at the Trust to transform our patient interpreting approach. ▪ Dr Roger Chinn, Medical Director for Chelsea and Westminster Hospital NHS Foundation Trust and medical director lead for the sector's acute care programme, reflected on how the involvement of lay partners in the acute care board and in major initiatives within the acute care programme – such as the development of an elective orthopaedic centre and community diagnostic centres – is making a difference. ▪ Dr Anne Kinderlerer, Associate Medical Director for St Mary's and Western Eye hospitals and consultant rheumatologist, reflected on why the need to embed co-design and involvement further at every level of the Trust, in particular highlighting the benefits of having the chair of the Strategic Lay Forum as a member of the Trust's Clinical Reference Group throughout the pandemic as well as adopting 'what matters to you' into clinicians' day to day practice and evaluation. <p>Trish Longdon also laid out the Strategic Lay Forum priorities for 2022/23 which were:</p> <ol style="list-style-type: none"> 1. Renewed emphasis by Trust leaders on user-focus and co-design with patients and communities 2. The development of Trust wide leadership and frameworks for cross cutting issues which need to be all our business, highlighting end of life care and care integrated around patients 3. Reducing health inequalities and promoting equity

<p>10.4.</p> <p>10.5.</p> <p>10.6.</p> <p>10.7.</p> <p>10.8.</p> <p>10.9.</p>	<p>4. Effectively introducing lay partners into the development of NWL strategies and plans and the strategies and plans for all our hospitals and health services.</p> <p>Kay Boycott enquired about the level of support required from the NEDs in order to grow patient leaders. Trish confirmed that central support was key in order for them to do their jobs effectively, and without that it could be quite lonely and difficult. Being heard and with real intention to take patients views into account was very important.</p> <p>Peter Goldsbrough wanted to hear more about the integrated user insight and dialling of patient and non-patient needs. Raymond Anakwe supported the view that this was an area that had cross cutting themes and clarity was being sought who actually owned this area which continued to give focus.</p> <p>Trish Longdon cited there was a need to triangulate and inform the strategy, plans and user insight was very important. To be involved in strategic projects early on and extend that support across the sector to ensure that there were no missed opportunities.</p> <p>Tim Orchard thanked Trish Longdon for the constructive challenges and for keeping the Trust grounded. The Board was informed that the Trust complaints function was now being managed by the Communications directorate under Michelle Dixon. Tim Orchard reflected on his own interest to reach the single patient system across the Acute Collaborative as it would be hugely beneficial with the support of the new user insights function.</p> <p>Matthew Swindells added that he looked forward to working closely with the Strategic Lay Partners and Lay Forum across the sector on the wider strategy.</p> <p>The Board noted the report and supported the strategic lay forum priorities for 2022/23.</p>
<p>11.</p> <p>11.1.</p> <p>11.2.</p> <p>11.3.</p> <p>11.4.</p> <p>11.5.</p>	<p>Integrated quality and performance report</p> <p>The Board received the integrated quality and performance report for month 12, summarising performance against the key performance indicators for March 2022.</p> <p>Raymond Anakwe presented key highlights:</p> <p>Harm - The harm profile remained good or low, and continued to rank significantly low in terms of the Trust’s mortality reporting using both the HSMR and the SHMI. The Trust had declared another never event, involving the insertion of the coil. There was no harm to the patient and the patient decided to keep the coil, and a number of measures had since been adopted in response.</p> <p>HSMR / SHMI - Julian Redhead advised that the Trust had fallen out of the top five in the HSMR rankings, but that mortality rates had not deteriorated. The Quality Committee had conducted a ‘deep dive’ review of mortality and was assured as to the Trust’s position and measures being taken to ensure the Trust maintained its good performance in this area. The review did not find any issues in terms of individual specialities and was around coding and relative coding between different Trusts. Since the Trust reviewing data in this way, it had always maintained its position within the top 5 best performing Trusts based on 12 months rolling data, although there is occasionally fluctuation on a monthly basis.</p> <p>Maternity and neonatology - The HSMR across the country in maternity and neonatology was not very well represented in that population and work was underway with Imperial College London (ICL) in terms of coding and how HSMR was used in those areas. The other learning aspect was around mortality and morbidity meetings and a large review was underway across the Trust.</p> <p>Never Events – There was a never event from the centre around blood transfusion and ABO incompatibility. During the investigation, it was found that the blood that</p>

was given was not ABO compatible, and not the blood that was actually ordered and it was highly important to note the learning from that.

Questions from the Non-Executive Directors

- 11.6. Peter Goldsbrough stated that quality improvement and safety were all about continuous improvement and sought clarity on reviewing the assurance processes.
- 11.7. Raymond Anakwe confirmed there had been a general increase in incidents of harm across the country. Identified themes were the same locally and undertaking work around human factors, teamwork, and integration and joined up working. There was a list of never events which was updated systematically, and referred to the processes, policies, training, education that were in place to support staff to prevent those episodes from happening again.
- 11.8. Kay Boycott referred to the incident reporting card which was rated green and noted much work had been invested and asked to hear about the success that had been achieved. Her second query was around the quality and performance scorecard which had a number of red areas, to understand the context and actions.
- 11.9. Raymond Anakwe paid credit to the team for their hard work on incident reporting. Despite the operational pressures, there was a real sense of increased awareness amongst the teams in the divisions across the organisation that they could contribute to patient safety, maintain standards and quality. Julian Redhead also added that there needed to be an easier way to collect data across the Trust in terms of potential issues occurring, to investigate and to learn from them.
- 11.10. Claire Hook introduced key three key items from the performance report:
- 11.11. **Elective Activity** – Elective activity was increasing but not increasing in step with the trajectory that had been set as part of the planning round and reason for which may be due to case mix. Referrals had increased over the last few months and was being reviewed as part of the demand and capacity planning. A review had been completed which looked at the operational environment over the summer so colleagues could take their breaks. Despite the challenges of the heatwave, travel disruption, monkeypox, demands on urgent and emergency care the service still managed to deliver for its patients.
- 11.12. **Cancer performance** – There had been good progress with the two week waits and good progress with the new faster diagnostics standard. There had been more patients waiting for treatment on the 62 day pathway, noting some of those were around capacity issues within the pathway of diagnostics, pathology and theatre scheduling with plans in place to address those. Patients who are transferred in for their cancer treatment having started their pathway at another Trust, was another area that needed reviewing across NWL. The Trust had already partnered with the Royal Marsden to review the data to leverage capacity and ensure patients were getting treated quickly.
- 11.13. **Urgent and Emergency Care** – In terms of ambulance handover times Charing Cross Hospital had the lowest number of delays though St Mary's was challenged. It was noted that the Trust had under performed in this area. The national operating standard for 2022/23 was 95% handovers within 30 minutes.
- 11.14. Tim Orchard emphasised there were a couple of areas of key focus for the Trust around 63 day waits and noted that the charts may not be the best way of illustrating or tracking the data. The cancer pathways was another good example for the Acute Collaborative to stop those breaches from happening and ensured patients were treated as quickly as possible.
- 11.15. **The Board noted the report.**

12.	Infection Prevention and Control Quarterly report (Quarter 4, 2021/22)
12.1.	The Board received the quarterly update of key indicators and infection rates, indicative of effective infection prevention and control (IPC) practice.
12.2.	Raymond Anakwe updated the Board that the focus was on a new learning package which was launched across the Trust and involved e-learning to address some of the issues around screening and sepsis.
12.3.	The Board was informed that Dr James Price was leaving the Trust and had been an incredible force and support to staff during the pandemic. In the interim, Raymond Anakwe would take on some of the board reporting functions whilst they recruited substantively to the post.
12.4.	The Board noted the report.
13.	Hospital Mortality Associated with Covid-19
13.1.	The Board received the report and noted that the Trusts within NWL Integrated Care System (ICS) had worked together to undertake a retrospective review of the care given to patients who died in hospital of Covid-19 during the first two waves of the pandemic.
13.2.	Raymond Anakwe articulated to the Board that Covid had been devastating and it was impossible to understate the pace of learning. The Trust undertook a rigorous approach to review of each patient who died and those who had hospital acquired Covid. The review included using the medical examiner team and structured judgment reviews. Each individual case had been reviewed by the Collaborative Panel chaired by the Medical Director, Julian Redhead, Raymond Anakwe with involvement and support from infection prevention and control, divisional and clinical colleagues and non-clinical colleagues.
13.3.	The outcome was they had not identified any significant lapses of care and there was nothing more that could have been reasonably done to avoid the acquisition of infection. Themes had been identified, areas for improvement in how Covid was managed, mortality processes and investigations. The plans for the site redevelopment and the constraints around space, ventilation, opportunities for patient flow etc. would feed into future work.
13.4.	Tim Orchard noted that in the Intensive Therapy Unit (ITU) mortality dropped by 27% between wave 1 and wave 2. The Board would need to make a decision about what were the key things that needed to happen with the Trust's estate. The separation of emergency and elective pathways was a critical subject and separation in the future was going to be really important, not just for the patients who had the condition but for the other healthcare conditions.
13.5.	Julian Redhead concurred that the learning which had come out through the CRG, through the pandemic had been fed automatically into the policies and procedures.
13.6.	The Board recognised that it was an incredibly difficult time, particularly for patients who were in hospital and those who were not able to be visited by their loved ones and their families and hoped that the families and loved ones would accept their condolences which were heartfelt and also that they might take some comfort from.
13.7.	The Board noted the report.
14.	Improving Equity in our Service Delivery
14.1.	The Board received the report which set out the ambition required to identify and address inequity in services provided across the Trust.
14.2.	Bob Klaber presented to the Board that equity was described as one of the domains of quality. Covid had shown was a very strong floodlight on issues of equity and in the delivery of healthcare services, in access to experience and of outcomes achieved. The report described a two year programme of work focused on a long

<p>14.3.</p> <p>14.4.</p> <p>14.5.</p>	<p>term approach to continuous improvement and systematically embedding equity. Equity is a key domain of quality, and in order to deliver a high quality service equity needs to be a central part and then to build on the experience, expertise, and infrastructure across the Trust and across the wider partners in NWL.</p> <p>Bob Klaber noted the importance of linking with colleagues working on EDI would be critical and would add real value. The next step was an engagement exercise and asking people what mattered to them.</p> <p>The Board agreed to the following:</p> <ol style="list-style-type: none"> 1. Accepted and adopted the level of Trust-wide ambition and focus required to assess and improve equity in the service delivery. 2. Accepted the recommended work stream and high-level activities so these could be formalised within a detailed 2-year programme of work. 3. Endorsed the move to view equity as a domain of quality and support scoping of a roadmap which looked to integrate equity into the existing Trust quality infrastructure. <p>The Board noted and agreed with the recommendations as set out in the report.</p>
<p>15.</p> <p>15.1.</p> <p>15.2.</p> <p>15.3.</p> <p>15.4.</p>	<p>National Audit of Care at End of Life Summary</p> <p>The Board was presented with the audit which focussed on the quality and outcomes of care experienced by those in their last admission in acute or community hospitals.</p> <p>Katie Urch briefed the Board that Katherine Buxton had led the end of life service and was driving much of the quality improvements from the patient, carer perspective through to the end of life.</p> <p>Tim Orchard stated it was a very helpful and important audit and that there was clear areas where the Trust was under performing and to ensure the Trust invested in the educators to provide the on-site 24/7 support and also highlighted the urgency in upskilling staff Trust-wide whilst noting this was an important area for the ICB to pull the different elements of healthcare together</p> <p>The Board noted the report.</p>
<p>16.</p> <p>16.1.</p> <p>16.2.</p> <p>16.3.</p>	<p>Complaints and PALs Annual Report</p> <p>The Board received the report which also explored categories and themes identified during the year and improvement initiatives that had been developed as a result of learning from complaints.</p> <p>Michelle Dixon explained to the Board that complaints were in line with pre-pandemic levels. PALs were continuing to increase and thematic issues identified. The team had been responding quickly to complaints with feedback and bringing together other initiatives such as the Patient and Public Involvement (PPI), other insights and user focus functions.</p> <p>The Board noted the report.</p>
<p>17.</p> <p>17.1.</p> <p>17.2.</p>	<p>Board Summary Report Quality Committee, 7 July 2022</p> <p>The Board received the Quality Committee Board Summary report.</p> <p>Bob Alexander referenced to the deep dive of the ambulance handover and also</p>

17.3.	<p>pointed out to the Board that he is a Board member on the London Ambulance Service (LAS). The Committee took much assurance with the ambulance handover times that work was underway to address the performance issue in comparison to other Trusts.</p> <p>The Board noted the report.</p>
18.	Finance Report
18.1.	The Board received and noted the financial performance report for month 12.
18.2.	Des Irving Brown presented a brief update the original plan submitted in April 2022 with a £10 million deficit had been acknowledged and the Trust would receive an inflationary budget of £10m from the funding envelope which meant the Trust would break even.
18.3.	The Board noted the report.
19.	Board Summary Report: Finance, Investment & Operations Committee, 6 July 2022
19.1.	The Board received and noted the Finance, Investment & Operations Committee Board Summary Report.
19.2.	Bob Alexander highlighted there would be a shift from the well-constructed framework into a very robust and rigorous set of delivery, in order to see the bottom line. It was important to see the reconciliation between improving elective activities and what that actually meant in terms of financial contribution from the Centre as that would help shape and de-risk issues later on in the year.
19.3.	The Committee was supportive of the reframed financial performance framework and which focussed on parts of the organisation that were particularly challenged in the financial delivery this year.
19.4.	The Committee was keen to see how the business partnering conversations would develop during the rest of the financial year to underpin the finance and operational delivery in 22/23.
19.5.	The Board noted the report.
20.	People Performance Scorecard Report
20.1.	The Board received and noted the People Committee scorecard report.
21.	Board Summary Report: People Committee, 5 July 2022
21.1.	Bob Alexander reported that the Committee recognised the challenges and was assured by the range of actions being undertaken and supportive of areas for innovation and hoped the Collaboration would provide some level of flexibility going forward.
21.2.	The Board noted the report.
22.	Board Summary Report: Audit, Risk and Governance Committee, 13 July 2022
22.1.	The Board received and noted the Audit, Risk and Governance Committee report.
22.2.	Kay Boycott summarised key points from the report. The Committee had spent time on the external audit and signed off the annual report. An independent review of the

22.3.	<p>process was due at its September 2022 meeting. Subject Access Requests were being monitored as part of the risk and assurance report. There were changes to the risk ratings for the redevelopment of the Mint Wing in the corporate risk register.</p> <p>The Board noted the report.</p>
<p>23.</p> <p>23.1.</p> <p>23.2.</p> <p>23.3.</p>	<p>Board Summary Report: Redevelopment Committee, 12 July 2022</p> <p>The Board received and noted the Redevelopment Committee report.</p> <p>Bob Alexander informed the Board that the Committee was well versed on the risks associated with the estates and contingency planning. The Committee was disappointed the difficulty the new hospitals programme had experienced which also impacted on progress of the programme. The Committee was considering how it might reshape some of the management of the redevelopment, particularly around assurance and how risks were identified and managed at the Committees.</p> <p>The Board noted the report.</p>
<p>24.</p> <p>24.1.</p>	<p>Any Other Business</p> <p>Tim Orchard made a general comment that the Trust from an operational perspective had performed remarkably well given the challenges, and that was entirely down to its staff. He felt it was important to acknowledge that staff had been incredibly flexible in dealing with whatever complexities / issues they have faced or had to deal with. He also gave his personal thanks to the Non-Executive Directors who were departing.</p>
<p>25.</p> <p>25.1.</p> <p>25.2.</p> <p>25.3.</p>	<p>Questions from the public</p> <p>Questions were posed to the Board and a written response would be sent later to two members of the public. Tim Orchard also suggested a separate meeting with the two public members.</p> <p>The Board was asked to make sure that in creating the Collaborative we were not distancing the decision making from our local communities. Tim Orchard responded that having patient voice was key to ensure a transparent approach with regular engagement and meetings. To ensure patients voices were involved in many of the aspects that involved the Trust. He noted that the Trust may not always get it right but to address it when it happened and improve on it. To ensure the local population had equal access and opportunity around the healthcare that is delivered, and received the same high standard of care.</p> <p>A question was asked around the prosthetics service. The member of the public highlighted various concerns: the shortage at the limb fitting centre, the impact that has had on disabled patients, the financial issues at the centre as it could not recruit and retain staff and the renovations which were carried out during the pandemic. The member of the public also pointed out that in his view 80% of the work was now outsourced to a company based in Sheffield. There were initially four qualified technicians and now there were only two and physio could not recruit more staff due to lack of funding. Patients were now waiting 45 days for their prosthesis rather than 2 days. The suggestion posed to the Board was for Charring Cross Hospital to provide the service for its local people rather than outsourcing.</p>

25.4.	<p>Tim Orchard responded the Trust had invested money on refitting and refurbishing the centre. The issue of failure to recruit was not about a failure to invest. It was a reflection of the health service in general about recruitment. The Trust was giving opportunities for staff with disabilities to ensure that they are fully represented across the workforce. Tim Orchard was concerned to hear about people who are waiting two days were now waiting 45 days for their prosthesis. Tim Orchard assured the member of the public that a review would be conducted on that service and how it was functioning for patients.</p> <p style="text-align: right;">Action: Tim Orchard</p>
25.5.	<p>Tim Orchard specifically requested that individual member of the public to put in writing his own case and any other questions he may have.</p>
25.6.	<p>A question from the public when patients were discharged were they aware which patient discharge pathway they were placed on? Tim Orchard responded patients, when they are discharged should have a very clear understanding of what support it is that they need. The ICB made an important point around discharge, which is being reviewed by the Trust to ensure it is timely and appropriate. The Trust as part of its major improvement priorities over the summer and into winter, would be focusing on each ward, a multi-disciplinary board so the doctors, nurses, allied health professionals make the right decisions, make sure they are communicated to the patients in good time and to have a clear set of actions that lead up to discharge so that nobody is surprised at the point of discharge.</p>
25.7.	<p>Matthew Swindells thanked all for their contributions and closed the meeting.</p>
26.	<p>Date of next meeting</p>
26.1.	<p>Wednesday 21 September 2022 at 11:00 – 13:30.</p>

Updated: 29 July 2022 / SH

LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST BOARD

**Public Minutes of the meeting held on
27 July 2022, 10.00-12.30pm**

DUE TO COVID-19, Members of the Public were invited to attend Via MS Teams

Members of the Trust Board met in person where possible in

Himsworth Hall, Medical Education Centre, Northwick Park Hospital,

Watford Road, Harrow HA1 3UJ

Members

Name	Role
Matthew Swindells (MS)	Trust Chair
Janet Rubin (JR)	Non-Executive Director/Vice Chair
Andrew Van Doorn (AvD)	Non-Executive Director
Dr. Syed Mohinuddin (SM)	Non-Executive Director
Dr Vineta Bhalla (VB)	Non-Executive Director
Professor Desmond Johnston (DJ)	Non-Executive Director (via Teams)
David Moss (DM)	Non-Executive Director
Kingsley Peters (KP)	Associate Non-Executive Director
Pippa Nightingale (PN)	Chief Executive Officer
Phil Spivey (PS)	Interim Chief People Officer
Lisa Knight (LK)	Chief Nurse
David Searle (DS)	Director of Corporate Affairs
Jonathan Reid (JRe)	Chief Financial Officer
Dr Jon Baker (JB)	Chief Medical Officer
John Watson (JW)	Divisional Director, St Marks (on behalf of James Walters, Chief Operating Officer)

In attendance

Name	Role
Jayne Hawkins (JH)	CQC Inspector (via Teams)
Kofo Abayomi (KA)	Head of Corporate Governance/Assistant Trust Secretary (minutes)
Rivka Lewis (RL)	Interim Head of Communications
Annika Towell (AT)	Head of Patient Experience (Item 5)
Renton Lheureux (RL)	Consultant Paediatrician (Item 5)
Maxine Chong (MC)	Director of Midwifery and Gynaecology (Item 5)

Apologies

Neville Manuel (NM)	Non – Executive Director
Huda Asad (HA)	Associate Non-Executive Director
Simon Crawford (SC)	Deputy Chief Executive Officer
James Walters (JW)	Chief Operating Officer

1. Welcome and Apologies for Absence

The Chair welcomed members of the Trust Board and attendees the meeting.

2. Declarations of Interest

2.1 There were no new declarations of interest at this meeting.

3 Minutes of the meeting held on 25 May 2022

3.1 The minutes of the meeting held on 25 May 2022 were approved as an accurate record.

4. Matters arising and review of action points

4.1 The Board reviewed and received updates on the action log, including actions arising from previous meetings.

5. Patient Story

5.1 JB introduced the patient story, which detailed the maternity and neonatal services experience of a mother who had a premature birth at Northwick Park Hospital. The story highlighted positive care experiences from the maternity and neonatal unit team but also reflected some aspects of care that were less positive and could serve as point of improvement. Feedback received from the family's experience were taken onboard as learning. The Board noted ongoing care provided to patients and their neo-natal journey. RL highlighted the importance of getting the care right the first time and described the work and interventions available to families.

5.2 In response to questions raised by SM which included how care is tailored to the diverse patient population of the Trust; whether the midwifery team is sufficient to support families and plans in place for mothers who do not wish to receive attachment support, MC confirmed that there was adequate midwifery support. Each patient had 1:1 support. In terms of the diverse patient population and attachment support, MC explained that a personalised approach/interventions are carried out.

5.4 The Board noted and thanked the family and the team for the patient story.

6. Chairman's Report

6.1 MS summarised his activities since the last Trust Board meeting which included meeting staff, stakeholders, and site visits. He also provided background and context to the acute collaborative and plans for recovering services.

6.3 The Board noted the report.

7. Chief Executive's Report

- 7.1 PN thanked the executive team and all staff of the organisation for their dedication and hard work. A number of challenges had arisen since the last reporting period, and this included another wave of Covid-19 infection and the recent heatwave. Trust staff were becoming even more resilient and adapting to working in challenging conditions. The recent heatwave also highlighted the need for a fit for purpose estate. Key points of the report included:

Emergency department operational performance – performance reported 73.5 percent for June 2022. This is the sixth highest performance in London for the 16 acute trusts reporting against this standard. There were 4,395 arrivals by ambulance in June 2022. The Board noted that although there was a rise in attendance, admission was low. The Trust continued to work with the Ambulance Service to mitigate pressures.

Staff Excellence Awards – the event was well attended, and it was the first event since covid-19 restrictions were lifted.

Way Forward stakeholder event - On the 6 July the first of our stakeholder events was held to help refresh our Trust's strategy - Our Way Forward.

Health and Wellbeing Day - In the last week of June a significant number of staff attended events to mark World Wellbeing Week. Around six hundred staff attended an event at Ealing Hospital, some 400 at Central Middlesex Hospital and over 1,000 staff attended at Northwick Park Hospital. A range of activities and sessions took place and 73 staff received health checks

NHS birthday and celebration of HEART values - The celebration was also an opportunity to change the E in HEART from equality to equity, and to introduce a new set of behaviours associated with each value.

Clinical Research Facility Opening event - Our Clinical Research Facility (CRF) at Northwick Park was officially opened on the 20 June by Dame Kate Bingham DBE. Kate was chair of the Government's Vaccine Taskforce during the Covid-19 pandemic. The Board noted that a Trust Consultant had been confirmed to work on sickle cell research, this reflected the diversity of the Trust population.

Project Search Internship Graduation: The Board noted that nine students from local colleges who have special education needs graduated after a two-year internship at the Trust. All nine were now in full time employment.

Elective Orthopaedic Centre: The Trust has now received confirmation to progress the Elective Orthopaedic Centre piece of work and proceed to public consultation.

Maternity: The Board noted that the maternity senior leadership team had now been strengthened and there is a maternity improvement plan in place.

- 7.2 AvD referred to the Trust objectives discussed at the last Board and the actions agreed by the board, AvD queried progress of the actions which included adaptation, risk registers and testing our resilience. PN advised that the objectives are still work in progress and yet to be implemented. In terms of delivery of the sustainability and adaptation plan, PN and JRe are developing the plan. JRe confirmed that more detailed work is underway to turn the Trust aspirations into a detailed plan.
- 7.3 MS referred to the recent heatwave and advised that thought must be given to managing future heatwaves. PN explained that significant health and wellbeing support was provided to staff to keep their morale up. MS stated that plans to be put in place should consider reducing the Trust's Carbon footprint. LK reported that a heatwave debrief will be carried out to determine what the Trust could have done better.
- 7.4 The Board noted the report.
- 8. Establishing the North West London Acute Collaborative**
- 8.1 MS introduced the item advising that this matter had already been discussed at three of the four acute trust boards in the collaboration and the Council of Governors of the Foundation Trusts. MS summarised the development of the collaborative and emphasised the importance of working in partnership. The paper described the strategic direction of the Collaborative and the governance arrangements to be put in place to achieve this whilst maintaining relationships with the local communities, Local Authorities, and public/patient engagement. The proposal will be reviewed in 12 months to determine whether it is still fit for purpose.
- 8.2 DS summarised the reporting and highlighted key sections to the Board. DS drew the attention of the Board to the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common (section 7); delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (section 10), the proposed meeting structure for the collaborative (section 10); the process for the initial NED appointments (section 12), the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (section 14) and the next steps (section 15).
- 8.3 DM expressed support of the direction of travel however he advised that local engagement aspect needed to be more robust. MS explained that the relationship with local communities is getting stronger. There had been extensive engagement with the Foundation Trusts Council of Governors, MS recognised that for the Trusts in the collaborative, a piece of work

is required to establish a lay forum to drive engagement. PN added that there is no one size fits all and some of the engagement would be tailored to local communities.

- 8.4 SM highlighted that NHS Trusts are seeing a heavy demand at their front doors and due to the size of the North West London patch, consideration should be given to primary care engagement. SM emphasised the importance of maintaining strong relations with North West London primary care. MS in response, highlighted that a big part of the collaborative focus is to deliver the interface i.e., getting patients into the right organisation and in the appropriate place. PN added that the place-based relationship will need to be strengthened and the ICS and acute collaborative will need to work closely together.
- 8.5 AvD recommended an independent review of the effectiveness of the governance arrangements over an internal review. He also advised that the independent review should be sought earlier than planned. AvD noted that, from the perspective of the Board as the corporate trustee for the London North West Hospital charity, assurance is required to demonstrate that the proposal will not frustrate LNWH charity aspirations of the organisation. Lastly AvD queried whether specific feedback was received from the regulators. MS advised that the charities in the collaborative are structured differently therefore more work will be done to align the charities. In response to feedback from the regulators, MS advised that the proposal was presented to the London team of the CQC, London region and Central team of NHSE/I and support of the model was received. CQC have not identified issues that could impact the well-led domain. The London region are enthusiastic about creating a line of decision making which optimises effectiveness. They had questions about the model and whether the model will allow sight of problems from board to ward. JR addressed the issue of independent assurance by stating that the model had to embed for a period before independent review.
- 8.6 AvD asked PN whether she was confident that the model will deliver the obligations of the Accountable Officer. PN confirmed this and explained that this was an opportunity to do things together, provide challenge across all of the Trusts in the collaborative and allow transparency of data.
- 8.7 KP asked whether other Trusts had a similar model and if there is a template from other trusts as guidance or comparator in implanting the model. MS stated that there is no template, the North West Acute Collaborative is the biggest collaborative in the country. The Board noted existing models and how these were different to the NWL collaborative model.
- 8.8 The Board:
- a) **Noted** the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common

- b) **Approved** the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common
- c) **Approved** the proposed meeting structure for the collaborative
- d) **Approved** the process for the initial NED appointments
- e) **Approved** the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders
- f) **Noted** next steps.

9. **Annual Infection Control and Prevention 2022**

- 9.1 LK presented the report which provided an update and governance of the Trust infection control and prevention (IPC). The Board noted that significant work was done to address the Covid-19 omicron variant. LK summarised the report highlighting the IPC performance against targets.
- 9.2 The Board noted the update on water safety and that no cases of legionella were reported in the Trust. There is a task and finish group on water safety. AvD commented that mitigations by the Estates team appear effective as there were no outbreaks of legionella in the previous year. PN commended the IPC team who were now supporting neighbouring Trusts in infection control and prevention.
- 9.3 The Board **approved** the report.

10. **Safeguarding Children and Adult Annual Safeguarding Report**

- 10.1 LK presented the report, highlighting that safeguarding governance structure was well embedded with excellent relationships with the Local Authority safeguarding team. LK summarised key achievements during 2021/22 and key priorities for 2022/23.
- 10.2 The Board noted that there was an increase in Deprivation of Liberty Safeguards (DoLS) requests, as a result the trust has increased its dementia team. More work is being done to determine what is driving the DoLS requests. In regard to Child and Adolescent Mental Health Services (CAMHS), referrals are increasing nationally, and a number of children are waiting for Tier 4 beds.
- 10.3 The Board **approved** the report.

11. **Annual Complaints Report**

- 11.1 JB presented the report which presented the annual data for Complaints and Patient Advice and Liaison Services (PALS) in the Trust. The key finding is improved complaints performance of 88% compared with 58% 20/21. In relation to Trust activity 0.10% patients made a complaint. The most prominent theme for complaints is Clinical Treatment and Communications, which is consistent with national data.
- 11.2 The Board **approved** the report.
- 12. Annual Organ Donation report**
- 12.1 JB presented the Organ Donation annual report for 2021/22 which highlighted the Trust's overall performance; LNWH benchmarking versus UK, donation after activities (brainstem and cardiac arrest deaths), quality metrics, staff and changes and challenges for 2021/22. The Trust remained a level 2 Trust in 2021/22 (6-12 preceding doners/year) and this was the best ever year for quality of process and outcomes for organ donation.
- 12.2 The Board **approved** the report.
- 13. Review of Standing Financial Instructions, Standing Orders and Scheme of Delegation**
- 13.1 JRe presented the report and explained that the Audit Committee reviewed proposed changes to the Trust's Standing Financial Instructions, Standing Orders and Scheme of Delegation at its meeting on 15th July. The proposed changes had been prepared jointly by the Finance, Procurement and Corporate Affairs departments. The purpose of this annual review was to identify any changes necessary to update these documents, taking account of the new Department of Health and Social Care guidance and regulations; changes in the Trust's internal governance arrangements and changes to enhance and improve the administrative efficiency of the Trust while maintaining an appropriate and effective framework of internal controls.
- 13.2 The Board noted that the Director of Corporate Affairs was working with acute collaborative colleagues to develop a governance protocol defining the proposed delegation of certain powers and responsibilities from the NWL acute Trust Boards to the NWL acute collaborative board-in-common. It is anticipated this governance protocol will be presented for discussion and comment to the next Audit Committee meeting scheduled for October. The governance protocol may therefore necessitate further changes to the Trust's SFIs, Standing Orders and Scheme of Delegation at that time.
- 13.3 The Board **approved** Standing Financial Instructions, Standing Orders and Scheme of Delegation.
- 14. Integrated Quality and Performance Report – June 2022 (Month 3)**

- 14.1 The report was presented by JB and JW. The Board was asked to note the following key headlines:
- Stroke service performance was impacted due to the recent wave of the pandemic, where capacity for beds on the stroke wards was limited, especially due to a reduction in repatriations to local stroke units with no admission capacity. PN provided assurance to the Board about plans across the collaborative to improve stroke services including joint performance recruitment
 - Highest ambulance attendance in London and the position remained pressured
 - Work continued to recover the Trust cancer position
 - Referral To Treatment (RTT) performance was 66% against national standard at end of June, with 0% on 104-week waiters.
- 14.2 AvD commented on re-admission rates and queried assurance in place that quality of care is not compromised due to the pressure on discharge. PN advised that more work is required to mitigate the risks arising from this issue.
- 14.3 SM queried factors driving staff turnover. PS explained that exit interviews are carried out with details reported in the workforce report however more work is still required to address staff turnover. PN added that more attention needs to be paid to staff turnover due to relocation.
- 14.4 JRe presented the finance report, advising that there are challenges around the delivery of the financial plan. The Board noted that the grip and control plan is maturing and providing the necessary assurance. JRe also advised that the underlying financial position is slightly challenged, a refreshed plan was submitted to address the shortfall due to inflation. The Board noted that the key areas of risk in the financial plan were delivery of the Elective Recovery Fund (ERF), inflation, and delivery of the savings plan.
- 14.5 The Board discussed the financial position and agreed that going forward, there will be an executive attending financial meetings to provide sufficient challenge.
- 14.6 VB enquired whether there is pressure arising from pay rise. She asked how this will be funded and where will assurance be provided. JRe explained that pay rise will be fully funded by the centre therefore there will be no pressure on the Trust. JRe advised that assurance will be provided to the Finance and Performance Committee.
- 14.4 The Board noted the report.
- 15. Finance and Performance Committee Chair Report**
- 15.1.1 DM on behalf of NM, advised that the Committee is placing emphasis on the pace and acceleration of transformation. The Committee also discussed the diagnostic centre and

considered BAF risks. There was a recommendation from the Committee to remove SR6 (decommissioning of specialist services) from the BAF.

15.1.2 The Board noted the update.

15.1.3 Finance Report

15.1.4 The Board **noted** the report.

16. Quality and Safety Committee Chair Report

16.1 VB advised that the Committee discussed serious incidents and learning from patient deaths, maternity risks with focus a on key learnings.

16.2 Serious Incident Report

16.2.1 Noted.

16.3 Learning from patient deaths

16.3.1 Noted.

17. Audit Committee Chair Report

17.1 AvD advised that the Committee signed off the Annual Report and Accounts, the referral to Secretary of State and the Annual Governance Statement. The Committee also considered the draft Quality Accounts.

17.1.2 The Committee considered two Internal Audit reports (data security and governance of St Marks). The Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation were also considered. The Committee received the Risk Register and Board Assurance Framework and the Committee expressed concern that risk, and issues were not being differentiated.

17.2 Trust Risk Report

17.2.1 Noted.

18. People, Equality and Inclusion Committee Chair Report

18.1.1 JR, advised that the Committee considered nursing recruitment, which was challenging, vacancy rate in midwifery was at 23% but this was mitigated by temporary staffing.

18.2 Workforce Report

18.2.1 Noted.

18.3 Nurse Staffing Report

18.3.1 Noted.

19 Charitable Funds Committee Chair Report

- 19.1 DM updated the Board on three key issues advising that there had been a fall in the value of the Trust investments due to the moving financial market, a Fund-Raising Manager had been appointed. The Charitable Funds had sponsored the Staff Excellence Awards which was a successful event.

Items for Information:

20. Trust Seal

20.1 Noted.

21. Approved Minutes from Board Committees

21.1 Noted.

22. Any Other Business

22.1 No other business was discussed at this meeting.

23. Questions from the Public

23.1 The Board noted that questions were received from a member of the public ahead of the meeting relating to the Establishment of the North West London Acute Collaborative. Some of the questions were covered during the item discussion. A written response would be issued covering questions asked and published on the Trust Website.

23.2 **A member of the public** asked the following questions:

Q. The Trust has plans to plant a tree at Ealing Hospital, what inscription will the written on the plaque.

A. PN advised following on from Adam Kay's book "This is going to hurt" there was a request a request to the Trust to plant a tree at the Ealing Hospital site and to mark the occasion. The wordings of the plaque will be "*In memory of Healthcare workers who died by suicide, take care of those who take care of others*".

Q: Regarding Patient Discharge there are 5 Pathways and patients are informed of the pathway they are on. There is a plan for weekend discharge which can be particularly difficult. What are your thoughts on this?

A. PN advised that the Trust has a comprehensive discharge team who agree pathway with patients and families. The discharge team work 7 days a week with clear communications with patients, relatives, and careers on which pathway patients are on.

Q. What is the plan for the car park at Ealing Hospital? It would be useful to have outpatients' radiotherapy unit on the former carpark site.

A. PN advised that there are ongoing discussion and a review of the estates of car park site at Ealing Hospital. Communication of the agreed plan will be communicated to stakeholders.

24. Meeting closed at 12.40pm



25. **Date and Time of the next meeting**
28 September, 10am-12.30pm

DRAFT

THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

DRAFT MINUTES OF THE BOARD OF DIRECTORS

Part-1 Meeting in public

Thursday 14 July 2022

Darwin Room, Brunel University Conference Centre and Via Microsoft Teams

Present voting:		
Matthew Swindells	Chair in Common	MS
Catherine Jervis	Vice Chair	CJ
Dr Linda Burke	SID/Non-Executive Director	LB
Simon Morris	Non-Executive Director	SM
Janet Campbell	Non-Executive Director	JC
Dr Ayesha Akbar	Non-Executive Director	AA
Patricia Wright	Chief Executive Officer	PW
Jon Bell	Chief Finance Officer	JB
Melanie Van Limborgh	Director of Nursing	MvL
Gubby Ayida	Medical Director	GA
Tina Benson	Chief Operating Officer	TB
Present non-voting:		
Sue Smith	Chief People Officer	SS
David Searle	Director of Corporate Affairs	DS
<p>Apologies: Tahir Ahmed - Director of Estates & Facilities Neville Manuel - Non-Executive Director Jason Seez - Deputy Chief Executive Officer and Director of Strategy</p>		
In attendance:		
Julia Masdin	Patient Story – Item 3	JM
Rana Erteza	Medical Devices Safety Officer	RE
Catherine Holly	Head of Patient Experience	CH
Lucy Wills	Communications	JMG
Paula Davis	Head Nurse in Planned Care	PD
Robbie Cline	Joint Chief Information Officer	RC
Graeme Wright	Deputy Director of Nursing (Workforce and Patient Experience)	GW
Vikas Sharma	Trust Secretary	VS
Leigh Franklin	Acting Assistant Trust Secretary (Notes)	LF
Governors:		
Tony Ellis	Lead Governor	TE
Ian Bendell	Public Governor	IBE
Harjinder Singh Hoonjan	Public Governor	HSB
Members of the public:		
Elaine Ling		

1	Welcome and Apologies for Absence	Action
1.1	The Chair welcomed all to the meeting. The Chair reminded everyone that the meeting was a meeting in public rather than a public meeting and that questions would be taken at the end.	
2.	Declarations of Interest	
2.1	There were no new declarations of interest.	
2.2	The Chair (MS) highlighted a declaration of interest already recorded that related to agenda item 8 the Digital Strategy. MS had been an Executive for Cerner corporation a number of years ago and is currently internal advisor to Accenture.	
3	Patient/Service story	
3.1	The Infant feeding co-ordinator and Specialist Midwife Julia Masden introduced Anusha a recent patient in the Trust's maternity service.	
3.2	<p>Anusha presented her story and experience of ante natal, labour and post-natal care in the Trust maternity unit.</p> <ul style="list-style-type: none"> • Anusha advised that this was her second child. She used the self-referral, on line form when she became pregnant, receiving a response within a week and appointments provided. Overall he had a relatively straight forward pregnancy, although the 20 week scan was carried out three times due to the position of the baby. When she had concerns around abdominal pains she used the phone line and was seen quickly on the day with tests completed and was sent home with reassurance. • She went into labour at 36 weeks, was seen within an hour and kept in, with transfer to a clean spacious room on the labour ward within two hours. She stayed overnight on the post-natal ward and was discharged the following morning. • She was readmitted as her baby daughter had neonatal jaundice and remained in hospital for 5 days. She experienced difficulties with breast feeding and sought advice. The Infant feeding team helped enormously with good advice that was carried through to the community breast feeding team. • Anusha advised the board that the pros included; exemplary staff in all areas but especially the feeding team. • The cons included; <ul style="list-style-type: none"> ○ The use of an app for appointments would be recommended. ○ Facilities: if staying in hospital for any length of time a private room would ensure privacy. 	

	<ul style="list-style-type: none"> ○ The birthing pool had not been available due to refurbishment ○ The ultra sound rooms in the maternity unit are quite small and cramped for three people with minimal ventilation ○ Food provided should be more nutritious especially for long stays ○ Bed sheets not changed regularly. ○ Daughter was diagnosed with tongue tie but in the community so picked up quite late. Is this a training need for staff in the maternity unit. Also, the only unit providing the surgery locally is in central London which is a long way with a new baby. 	
3.3	The Director of Nursing (MVL) thanked Anusha for her interesting personal story and confirmed that sheets are not changed every day but there does need to be a balance and she will review the current process.	
3.4	Non-Executive Director (LB) asked where would be a good place to engage with new mothers to help us learn about our services. Anusha said that trying to speak to parents about their experience before or on discharge is not a good place, it would be more beneficial to speak to people at children's centres, baby groups or post-natal groups where new mums would be more settled and able to discuss their experiences.	
3.5	The Board thanked Anusha for sharing her experience and for highlighting the areas in which the Trust can learn and make improvements.	
4.	Minutes of the previous meeting and matters arising	
4.1	The Minutes of the meeting held on 12 May 2022 were approved as an accurate record of the meeting.	
5	Matters Arising/Action Log	
5.1	The Board noted the actions on the action log were either complete, on the agenda or on-track.	
6	Chair's Report	
6.1	<p>The Chair (MS) presented the report providing an update on matters since the report was circulated:</p> <ul style="list-style-type: none"> • MS is continuing to meet and build relationships with stakeholders at all four Acute Trusts. • The private board meeting held on the 16 June formally approved the Outline Business Case (OBC) for the hospital redevelopment and the trust is now waiting to submit the OBC once the treasury have approved the central business case for the re-development programme. • MS advised that Steve Barclay, the Secretary of State for Health, had visited the Hillingdon Hospital site this morning. MS and PW had facilitated his visit. He is currently visiting the 	

	hospitals that are on the priority list for the national hospital's programme.	
7	Chief Executive's Report	
7.1	The Chief Executive Officer (PW) presented the report highlighting:	
7.2	<ul style="list-style-type: none"> • In her keynote speech, given at the NHS Confed/Expo Conference on 15 June, Amanda Pritchard, NHS Chief Executive, set out 'four Rs': Recover, Reforming, Resilience and Respect that form the most significant opportunities and challenges for the NHS going forward. This will inform the update of the NHS plan. • PW advised that we have the local Digital strategy on the agenda of the meeting. This is timely in that the Department of Health and Social Care had just published a plan for digital health and social care. It collates existing digital strategies, plans and guidance into one single action plan. • The first meeting of the NHS NW London Board took place on 1 July 2022, to ratify membership. The first full NHS NW London Board meeting will be on 19 July 2022 and updates will be provided to the Board. • Hillingdon Council officially received the planning application for the new Hillingdon Hospital on 22 June. A summary of the plans – including a scale model of what the new hospital might look like is available to see at an exhibition in Uxbridge Library until 27 July. There are also roadshows taking place and the borough are encouraging feedback to the application locally. • Katherine Ward and the Midwife-Led Unit are the first wards to gain a 'gold' rating under the Trust's ward accreditation system. Having met or surpassed a range of standards judged against criteria typically assessed by the Care Quality Commission during an inspection. • In line with National 'Living with Covid' guidance, we are gradually stepping down our IPC measures surrounding Covid-19. This includes changes to our patient pathways, which are now respiratory or non-respiratory. These changes came into effect on Monday 6 June. This has enabled the re-introduction of NED visits to the Trust and a plan for Governors visits on site. Members of the Executive Team and senior managers in the corporate and clinical divisions have also re-commenced visits to wards and departments with over 90 visits completed so far. 	
For Decision/Approval		
8	Digital Strategy	
8.1	The Joint Chief Information Officer (RC) advised the Board that, to support the Redevelopment of Hillingdon Hospital, the IT workstream has developed a Digital Strategy for the new hospital.	

8.2	The strategy presents the digital vision to stakeholders and to the public and has been developed to support the Outline Business Case (OBC). It incorporates collateral produced by the national hospitals team that sets out their expectation of technology in a modern hospital. It also incorporates work in the wider North West London community with greater sharing of information systems.	
8.3	The report has been reviewed by IT governance, re-development governance and the Re-development Programme Board and finally The Finance and Performance Committee and was now being recommended to the Trust Board for approval.	
8.4	The Non-Executive Director (SM) asked if there was sufficient funding and resources available to support the work. RC advised that there is a costed model supporting the document that won't cover all costs but does include funding required for training of staff to ensure a better IT experience. There will be items that will need to be funded through other sources and considered on their own merit and reviewed individually.	
8.5	The Chief Operating Officer (TB) said that although the digital strategy was a good ambition for the future she would have like to have seen more Artificial Intelligence (AI) included, understanding the national requirement to level up, this would be an efficiency gain going forward.	
8.6	The Chief Executive Officer (PW) advised that in her role as the Digital Senior Responsible Officer for IT in the acute collaborative and also the Integrated care system, the national priority currently is around the electronic patient record. Funding will come from the central team to ensure levelling up. This strategy is the right strategy currently but will be reviewed on a continual basis.	
8.7	The Chief People Officer (SS) advised that as part of the enabling element of the North West London future people strategy the people and OD teams will be looking to access information on AI for transactional services. There will be work undertaken in the Autumn specifically looking at recruitment services.	
8.8	The Board approved the Digital Strategy.	
9	N&M AHP Strategy	
9.1	The Director of Nursing (MVL) presented the Nursing, Midwifery and AHP final draft Strategy (2022-26).	
9.2	<p>The strategy details the:</p> <ul style="list-style-type: none"> • Engagement and development work for the refresh of the Nursing, Midwifery and Therapies strategy 	

<p>9.3</p> <p>9.4</p> <p>9.5</p> <p>9.6</p>	<ul style="list-style-type: none"> • A summary of the key findings and recommendations from staff engagement activities • Strategy for 2022-26, alongside enablers and measures of success • Plan for further review, launch and implementation alongside how the strategy will be monitored <p>The overarching ambition of the strategy is to recruit and retain a highly skilled nursing, midwifery and allied health professions workforce. Staff will be supported and developed, enabling teams to provide high quality care to patients, service users and their loved ones.</p> <p>It sets out how we will achieve a sustainable, equitable, knowledgeable and caring service. The strategy has been developed with input from nursing, midwifery and therapy colleagues and it will help to deliver high quality care.</p> <p>The Non-Executive Director (LB) asked how we will ensure that those staff that have not been included in the development of the strategy will be made aware of the plans. MVL said that the strategy will be presented at the Nursing and Midwifery senior meetings, will be presented to the divisional nursing teams and the different staff groups alongside media communications to distribute the information.</p> <p>The Board approved the N&M AHP Strategy.</p>	
<p>10</p>	<p>Annual Revalidation and Medical Appraisals</p>	
<p>10.1</p> <p>10.2</p> <p>10.3</p> <p>10.4</p>	<p>The Medical Director (GA) presented the annual board report for revalidation and medical appraisals for 2020/2021 and 2021/2022.</p> <p>The reports updated the Board on progress since 2019/2020, highlighted current and future issues and provided an update on how to mitigate potential risks.</p> <p>The Trust Board has a statutory duty to ensure that the Trust discharges its responsibility as a designated body in relation to the revalidation of Medical Staff. The report</p> <ul style="list-style-type: none"> • provides the Board with assurance that The Hillingdon Hospitals NHS Foundation Trust and the Responsible Officer are executing their duties in respect of Revalidation. • requests that the Board approve the Statement of Compliance. <p>The Board approved the Statement of Compliance document confirming that the organisation, as a designated body, is in compliance with the regulations and this will be signed by the Chief Executive for return to NHS England.</p>	

For Discussion	
11	Finance Report M2
11.1	The Chief Finance Officer (JB) presented the report highlighting:
11.2	<ul style="list-style-type: none"> • As at Month 2, the Trust has reported a position that is £0.2m favourable to plan with additional income from OSCI nurses and Drugs and Devices offsetting a £0.4m shortfall in activity related income. • CIP delivery of £0.6m year to date is ahead of plan by £0.2m although the phasing ramps up considerably from Q2. Of the full year CIP plan approx. £4.6m has been signed off with a further £3.0m as pipeline which still leave a shortfall to plan of £4.4m. • There has been a significant improvement in the run-rate compared to Month 12 (normalised) across both pay and non-pay. • Delivery of the 2022-23 plan is a key part of the first core workstream of the Recovery Support Programme (RSP) exit plan. • The Trust has a positive start to the year but acknowledges there will be further challenges in Month 5 and 6.
11.3	The Board noted the M2 finance report.
12.	CIP Delivery M2
12.1	<p>The Chief Operating Officer (TB) updated the Board on the Month 2 position in relation to CIP delivery highlighting:</p> <ul style="list-style-type: none"> • M2 Target was £240k, M2 actual delivery was £313k; Delivering 130% of M2 target • YTD target was £480k, YTD actual delivery was £618k; Delivering 5% of FY target • M3 Target is £240k, M3 forecasted delivery is £312k based on M1 and M2 performance analysis
12.2	The Board noted the CIP Delivery M2 update. It was noted that the biggest risk was in the continuing unidentified CIP. JB advised that are clear messages in divisions on financial spend and plans for non-recurrent mitigations.
12.3	The Non-executive Director (LB) commented that there are still issues around productivity in theatres and that activity is not quite where we would like it to be. The Chief Operating Officer (TB) advised that theatre utilisation has improved in month from 72% to 78%. There continues to be improvements in delivery of the elective target and the aim is to reach 100% of 19/20 baseline with no additional spend or risk to the financial position.
Committee Chair's Report and Committee Reports	
13	FPC Chairs Report
13.1	The Vice Chair (CJ) presented the report highlighting:

13.2	<ul style="list-style-type: none"> • Delivery of the CIP target. Best case now short of target but trust will be ensuring by year end that recurrent savings are in place and embedded. • The committee discussed:- <ul style="list-style-type: none"> ○ the A&E performance that continues to be challenging ○ Increase in over 52 week waits for RTT ○ Delays in Pathology which continue to challenge cancer performance for patients waiting over 62 days. This is being escalated daily. • The committee received the Q4 2021/22 Operating Plan update which demonstrated progress against all the Trusts strategic objectives and closing position at the end of the financial year. • The committee received the Internal Audit report into Core Financial Systems, and management assurance that actions to address the findings had either already been completed or on track to be completed by the end of July 2022. 	
13.1	Integrated Quality and Performance Report	
13.1.1	The Chief Operating Officer (TB) highlighted the areas of key risk:	
13.1.2	<ul style="list-style-type: none"> • A&E type 1 performance of 50% did not meet the targets of 53% for May. An increase of 7% in average daily attendances to the department from the previous month has impacted this. Patient experience was now a focus with waiting times increasing • Elective recovery is showing a month on month improvement but the rise in sickness levels with the new Covid infection wave and summer annual leave, means there is a risk to delivery of the plan even with the mitigations in place. • Over 78 week waiting patients now have detailed plans for management and numbers are declining. • The appraisal rate remains a concern although has improved in this month and continues to improve. • Pressure Ulcers remain in control limits but there continues to be further work to reduce numbers. 	
13.1.3	The Non-Executive Director (SM) asked about the number of stranded patients and what work is in place to reduce this number.	
13.1.4	TB reported that there is a rotational long length of stay review led by a clinical lead, taking place twice weekly on a patient by patient basis and the Trust continues to work with HHCP. SM asked if the themes were the same across the acute provider collaborative. TB said that some issues were similar. One of the challenges is that the investment put in place through HHCP on discharge to assess during	

	<p>Covid is non re-current funding and there are discussions around this within the provider collaborative.</p>	
13.1.5	<p>The Vice-Chair (CJ) recently attend the 'New Consultants Programme' and suggested that performance documents like the IQPR should be shared with new consultants regularly.</p>	
13.1.6	<p>The Chief People Officer (SS) advised that a paper has recently been approved by the Trust Management Board on key areas of action on sickness and work will now start in that area. The trajectory on appraisals for this month has met its target of 75%.</p>	
13.1.7	<p>The Chief Executive (PW) asked for assurance around the high vacancy rates in midwifery and what measures are in place. The Medical Director (GA) advised that we have been moving midwives to the areas of need and re-profiling regularly. There is work underway looking at other roles, career progression for maternity support workers and attracting people back to midwifery.</p>	
13.1.8	<p>The Board noted the IQPR and the Elective Plan 2022/23.</p>	
13.2	<p>Operating Plan 2021/22</p>	
13.2.1	<p>The Chief Executive (PW) presented a detailed update on the Quarter 4/year end operating plan 2021/22 and the six plus one* objectives for the Trust that aimed to deliver the mission and vision of the Trust as set out in the Trust Strategic Plan 2017-21.</p>	
13.2.2	<p>PW advised that the update demonstrated the progress that had been made during the year and highlighted those areas that need to be carried forward into the following year.</p>	
13.2.3	<p>The Non-Executive Director (LB) queried the rag rating and whether going forward there would be the need to quantify the ratings. PW advised that going forward there would be a link with the Trust Strategy, Operating Plan, IQPR and the Recovery Support plan to ensure progress on metrics are clearer.</p>	
13.2.4	<p>The Board noted the report.</p>	
14	<p>QSC Chairs Report</p>	
14.1	<p>The Non-Executive Director (LB) presented the report highlighting:</p>	
14.2	<ul style="list-style-type: none"> • The committee received CQC deep dive presentations from 6 core services and will receive the 3 remaining areas at its next meeting on 27th July 2022. • The committee reviewed the maternity safety report, noting continued challenges in recruitment. The QSC also reviewed progress against the Ockenden Final Report with 15 Immediate and Essential Actions (IEAs) to be implemented across maternity services in England and the Trusts self-assessment against these. 	

	<ul style="list-style-type: none"> The committee received the Final Quality Accounts for 2021/22. The committee noted good progress in quality and safety indicators and assurance generally. 	
14.1	Annual Infection Prevention Control Report	
14.1.1	The Director of Nursing (MvL) presented the report previously reviewed by the Quality and Safety Committee. She informed the Board of IPC performance in relation to Healthcare Associated Infections (HCAIs), challenges with COVID-19, audit performance, built environment and incidents and outbreaks.	
14.1.2	Performance in relation to HCAIs: <ul style="list-style-type: none"> Targets met for methicillin-resistant Staphylococcus aureus (MRSA), methicillin-susceptible Staphylococcus aureus (MSSA), Klebsiella spp. and Escherichia coli (E. coli) blood stream infections (BSIs). Performance on key performance indicators was better than that of other Trusts in the sector. 	
14.1.3	COVID-19 provided considerable challenges with regard to providing a safe environment for patients, staff and visitors. Improvements have been made in response to learning from outbreaks and incidents.	
14.1.4	Audit performance was sufficient to support the CQC Section Notices withdrawal in October 2021. However, audit results are below standard in some areas, and the IPC Team are providing support to the clinical teams to improve performance where necessary but there remain challenges.	
14.1.5	Considerable progress has been made in relation to water safety. This has been achieved through close working with the Estates and Divisional teams.	
14.1.6	Antibiotic stewardship work across the Trust continues in line with National requirements and recommendations.	
14.1.7	The Board noted the work ongoing to maintain and develop the IPC Service for the Trust, and provide support and resources and the activity and key themes for the year 2021-2022.	
14.2	Learning from Incidents Report	
14.2.1	The Medical Director (GA) presented the report which has been received and reviewed by the Quality and Safety Committee.	
14.2.2	The report provides assurance of compliance with our Incident Reporting requirements as well as the key areas of learning associated with the outcome of serious incident investigations. The report covers the financial year April 2021 – March 2022	
14.2.3	Key points to note:	

	<ul style="list-style-type: none"> • 127 SIs declared between April 21 and March 22 • Increase in SIs declared between April 21 and March 22 in comparison to the previous year • Key themes for SIs declared are hospital acquired pressure ulcers, Maternity related incidents and delay in treatment incidents. • The trust declared 3 Never Events between April 21 and March 22 • A number of new initiatives have been introduced to promote learning and to cascade key safety messages including a monthly “Learning Matters” poster to complement the existing learning and safety bulletin as well as the roll out of the “Learning Bites” video series. In addition there will be a weekly safety slot in Trust e-News and a safety stand to be held monthly in the restaurant along with patient safety ward visits • The Trust is currently awaiting the National introduction of the Patient Safety Incident Response Framework (PSIRF) 	
14.2.4	The Board noted the report.	
14.3	<i>Learning from Patient Deaths – Mortality report.</i>	
14.3.1	The Medical Director (GA) presented the mortality data for the Trust from February 2021 to January 2022 and Learning from Deaths for Q4 2021/22. The Hospitals Standardised Mortality Rate for Hillingdon is lower than the NHS benchmark for the latest January 2022 data update. This is the first time in the wider data range of the reporting in the last 3.5 years. However, it should be noted that these values are right on the edge of tolerance and may change in future. An update is also provided on the Medical Examiner Service.	
14.3.2	GA advised that the Trust is involved in an acute collaborative piece of work on hospital acquired Covid deaths between April 2020 and March 2021 and there will be a report presented to the next Board that will cover the data and the learning from this.	
14.3.3	The Non-Executive Director (SM) commended the work that has been undertaken by the team and the standard of the reports provided.	
14.3.4	The Non-Executive Director (JC) queried the gap analysis following initial review and the item rated red on ‘is the Trust assured that all divisions report their data in a meaningful way’. GA reported that this relates to M&M reviews in unplanned care. There have been some challenges in this area but it is hope that this issue will be resolved after July.	
14.3.5	The Chair (MS) advised that this was a helpful report. The Board noted the report.	

14.4	Safer Staffing Report	
14.4.1	The Director of Nursing (MVL) presented the paper on trend data and analysis for the financial year 2021/22 from safer staffing metrics reported monthly in the IQPR.	
14.4.2	<p>The Board were asked to note:</p> <ul style="list-style-type: none"> • Trust compliance with NQB and Developing Workforce Safeguards documents. • Action plan in place to address gaps. • Average fill rates have stabilised since September 2021. • CHPPD has decreased since Aug 21 but remains above the national benchmark impacted by the need for 1:1 enhanced observation, the impact of additional beds and environmental changes on ICU and NIV patients on ARCU, requiring a higher nurse: patient ratio. • Temporary staffing use remains high although there is a continued reduction in agency and off framework agency. • Actions taken to reduce temporary staffing use/spend outlined and drivers for use discussed. • Nurse staffing continues to be impacted by sickness absence at 6% for Nursing and Midwifery (target 3%) • Significant reduction in RN vacancy to 5.5 % at year-end as a result of international recruitment project. Further reduction to be noted. Risks impacting the project delivery were outlined. • There will be further data added to this report going forward. 	
14.4.3	The Chief Executive (PW) said that when visiting the wards it is often noted that the wards feel they are short staffed, although the regular reports provided show that staffing is well within, and in places, exceeding national standards, alongside the better control on the appropriate agency usage. Is there any way we can change the narrative on the staff perception. MVL said that we do need to ensure we raise this when having general discussions with all of our staff, and provide national data benchmarking to update them on current staffing levels.	
14.4.4	The Board noted the report.	
14.5	Ockenden Report Update	
14.5.1	The Medical Director (GA) presented the report update on the progress against the Final Ockenden Report 15 Immediate and Essential actions.	
14.5.2	A letter was sent to all Trusts on the 1st of April 2022 from Amanda Pritchard, NHS CEO, which acknowledged the Final Ockenden Report and asked Trusts to undertake a number of actions including assessing their staffing position and make a decision for their maternity service in relation to Midwifery Continuity of Carer. On review, the maternity unit currently falls into category 2 and will continue with existing Continuity of Carer teams but is not in a	

<p>14.5.3</p> <p>14.5.4</p> <p>14.5.5</p> <p>14.5.6</p>	<p>position to rollout any further teams until the building blocks of safer staffing are in place.</p> <p>Significant investment for maternity service transformation over the next 2 years (£127 million on top of the £95 million last year) has been announced. This will fund further workforce expansion, leadership development, and capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support.</p> <p>The service has undertaken a gap analysis on the Final Ockenden Report and has developed its action plan which has also been shared at the Quality and Safety Committee. An infographic has been developed to share the findings of the Ockenden Report with staff and service users. Engagement events with staff are in progress.</p> <p>All Trusts will be receiving an Ockenden Assurance visit between June and September and the visit at Hillingdon is planned for Friday 16th September 2022.</p> <p>The Board noted the report.</p>	
<p>15.</p>	<p>People Committee Report</p>	
<p>15.1</p> <p>15.2</p>	<p>The Non-Executive Director (SM) presented the report highlighting:</p> <ul style="list-style-type: none"> • Delays in receiving the EDI action plan and annual report • The committee reviewed people - related performance metrics in the IQPR and will received a deep dive into sickness absence and EDI in July 2022. • Medical Revalidation – The committee recommends the board approve the Designated Body Statement of Compliance <p>The committee received the following reports:</p> <ul style="list-style-type: none"> • People Strategy Annual Review • Guardian of Safe Working Annual Report • Medical Revalidation Annual Report • Safer Staffing (also via QSC) • Financial Recovery Programme - Workstream 5: affordable and deliverable workforce plan and associated risks 	
<p>15.1</p>	<p>People Strategy Annual Review</p>	
<p>15.1.1</p> <p>15.1.2</p>	<p>The Chief People Officer (SS) advised that the People and OD team have undertaken a review of Year 1 of the People Strategy actions to identify where progress has been made, where further work is required and where the original actions may require refining. It should be noted that although it is being described as Year 1 the strategy it was only approved in September 2021.</p> <p>It is important to note that the review of the People strategy is happening alongside delivery of current programmes of work identified within the strategy.</p>	

15.1.3	The Board noted the report.	
15.2	<i>Guardian of Safe Working Annual Report</i>	
15.2.1	The Medical Director (GA) presented the Guardian of Safe Working Hours (GoSWH) update. This is the annual report for 2021 covering the period between 1 November 2020 to 31 October 2021. The report seeks to review data and provide assurances to the board that doctors-in-training are working safe hours. The Trust is committed to supporting doctors who raise exception reports and ensuring that they are confident to raise issues when necessary.	
15.2.2	The Board noted the report.	
16.	ARC Chairs Report	
16.1	<p>The Non-Executive Director (SM) highlighted the following from the last meeting :</p> <ul style="list-style-type: none"> • The committee received the final two reports from the 2021/22 Internal Audit Plan <ul style="list-style-type: none"> ○ Patient Safety Data Quality (Hospital Acquired Pressure Ulcers & Patient Falls – ‘Partial Assurance with Improvement Required’. The committee however noted immediate action taken to strengthen data quality arrangements. ○ Strategic Risk Governance – ‘Significant Assurance with Minor Improvement Opportunities’ • The Committee received the final Internal Audit Report, and Head of Internal Audit Opinion of ‘Partial Assurance with Improvement Required’. The committee noted for the 2022/23 Internal Audit Plan a balance of areas of perceived weakness and review of previous audits where controls have been strengthened would be helpful. • The committee received the Draft Internal Audit Plan for 2022/23 from BDO, noting further executive engagement planned before the plan is approved in July 2022. The committee received assurance that handover is taking place between KPMG and BDO. • The committee received the Draft External Audit Report (ISA 260), and Draft External Audit Opinion. • The Committee approved the Annual Report and Accounts for 2021/22 which were submitted to NHSEI by the deadline of noon 22nd June 2022. 	
16.2	The Board noted the report.	
Items for Information		
17.	Quality Accounts 2021/22	
17.1	The Director of Nursing (MvL) presented the report which had been received and reviewed by the Quality and Safety Committee highlighting:	

17.2	The Trust has produced the 2021/22 Quality Account, which is a mandated document, laid before Parliament, before being made available on the NHS website, and our own website.	
17.3	This draft mirrors previous versions of the Trust's Quality Account and meets National recommendations as published.	
17.4	There is a national requirement to publish the Quality Account before 30th June 2022. The Board approved this final version of the report on 17 June 2022.	
17.5	The Board noted the report.	
18.	Board Committee Effectiveness Review 2021/22	
18.1	Each Board Committee undertakes an annual review of effectiveness and the reports summarise the key business of the following committees during the year of 2021-22: <ul style="list-style-type: none"> • Audit and Risk Committee • Quality and Safety Committee • Finance and Performance Committee • People Committee • Charitable Funds Committee • Board Nominations and Remuneration Committee 	
18.2	The Board noted the reports	
19.	Trust Seal	
19.1	The Board noted the use of the Trust Seal as follows:	
19.2	This report provides the details of documents signed under the Trust Seal since last reported to the Board on 12th May 2022: <ul style="list-style-type: none"> • Third deed of variation pursuant to section 106A of the town and country planning act 199. Between THHT - The London Borough of Hillingdon 	
ANY OTHER BUSINESS		
There was no other business to discuss.		
<u>Questions from Governors</u>		
<p>The Lead Governor, Tony Ellis said that there are wide variations on the waiting lists in North West London. What measures are being taken to mitigate those differences?</p> <p>The Chief Operating Officer (TB) said that the four acute trusts are collectively reviewing their waiting lists weekly, and highlighting where there are issues. For Hillingdon our challenge is in specialities Rheumatology and ENT. Plans are in place to but would expect to see improvement in Rheumatology in the next few weeks. We will then be looking at ENT, although all four providers in NWL have relatively long waiting lists but will be working through the lists together. MS said that it is important that all waits are determined by a patient's condition and not where they live.</p>		

The Lead Governor, Tony Ellis asked whether there would be any patient representation on the new Integrated Care Board (ICB). The Chair and Chief Executive advised that this is not currently a requirement but suggested that TE attend the next ICB meeting in public and ask the Board what their thoughts would be around patient representation.

Questions from the Public

None.

END

Next meeting: Thursday 15th September 2022, 10.00-12.00pm

DRAFT

THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

DRAFT MINUTES OF THE BOARD OF DIRECTORS
Part-1 Meeting in public
25 July 2022

Present voting:		
Matthew Swindells	Chair in Common	MS
Dr Linda Burke	SID/Non-Executive Director	LB
Simon Morris	Non-Executive Director	SM
Neville Manuel	Non-Executive Director	JC
Dr Ayesha Akbar	Non-Executive Director	AA
Patricia Wright	Chief Executive Officer	PW
Jason Seez	Deputy Chief Executive Officer and Director of Strategy	JS
Present non-voting:		
Sue Smith	Chief People Officer	SS
David Searle	Director of Corporate Affairs	DS
<p>Apologies: Tahir Ahmed - Director of Estates & Facilities Linda Burke- Non-Executive Director Tina Benson - Chief Operating Officer Jon Bell Chief - Finance Officer Gubby Ayida - Medical Director Melanie Van Limborgh - Director of Nursing Catherine Jervis - Vice Chair Janet Campbell - Non-Executive Director</p>		
In attendance:		
Catherine Holly	Head of Patient Experience	CH
Justine McGuinness	Head of Communications	JMG
Vikas Sharma	Trust Secretary	VS
Governors:		
Tony Ellis	Lead Governor	TE
Ian Burnell	Public Governor	IB
John Clarke	Public Governor	JC
Ian Bendell	Public Governor	IBE
Ahmet Moustafa	Public Governor	AM
Nicole Renninson	Staff Governor	NR
Natasha Wills	Appointed Governor	NW
Members of the public:	None	

1	Welcome and Apologies for Absence	Action
1.1	The Chair welcomed the Executives, the Non-Executives, Members of the Council of Governors and members of the general public to this extraordinary board meeting. The meeting was convened to cover the one item, establishing the North West London Acute Provider Collaborative.	
2.	Declarations of Interest	
2.1	There were no new declarations of interest.	
3	Establishing the North West London Acute Provider Collaborative	
3.1	The Chair (MS) explained that the purpose of this item is to seek approval from the four trust boards in north west London (Chelsea & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust) for the establishment of the north west London acute provider collaborative.	
3.2	The paper explained the range of governance changes which will support the establishment of the collaborative. It had been developed with input from the respective vice chairs and chief executives and chair-led discussions with trust boards and, for the two foundation trusts, councils of governors during June 2022, as well as input from key regulators, Care Quality Commission and NHS England (London).	
3.3	MS advised that one of the key points of learning from the COVID-19 pandemic was the success of the clinicians and the leadership teams across the four acute trusts operating together with a focus on the health needs of the people who live in North West London.	
3.4	The proposal is a new structure, maintaining four independent acute trusts with their entire executive teams and with the ability to have a full quorate board membership. Maintenance of relationships with their borough, their local authorities and their council of governors and all of their other critical stakeholders will remain unchanged.	
3.5	The four individual organisations, will continue to hold their key board committees (Quality Committee, People Committee, Finance and Performance and Audit Committee) responsible for overview and scrutiny of trust business. They will also be brought together into a collaborative Quality Committee, a collaborative Finance and Performance committee, a collaborative People committee and a collaborative Infrastructure & Capital committee that allows oversight more broadly across the collaborative.	
3.6	Each Trust will continue to have a full executive leadership team that is responsible for delivering excellence in their organisations, but at board level, we will be bringing the board together into a single	

	<p>Board In Common, which will be fully representative of the executive and non-executives across all organisations, and will meet in public as the board, with the first public board meeting to be held in October 2022.</p> <p>3.7 The Director of Corporate Affairs (DS) added that the paper presents the mechanics around how we will move the four independent organisations into collaborative working.</p> <p>3.8 Part of that methodology will be the Non-Executive Director appointments and to achieve the maximum collaboration we are using the model where we will share non-executives across the four acute trusts. There will need to be some constitutional amendments sought.</p> <p>3.9 The Chief Executive (PW) asked whether a review proposed for 12 months could be undertaken after 6 months. MS advised that we will continually review how the process is evolving and make small changes as we learn in real time and review those changes after 12 months.</p> <p>3.10 PW also asked if we continue to have a Remuneration committee at local level and at collaborative level would the collaborative Remuneration committee look to standardise practice across the collaborative. MS said that it would oversee more strategic agreements on job descriptions and salaries and look for more commonality.</p> <p>3.11 Non-Executive Director (SM) said, although he was supportive of the decision and advantages of this model, he had concerns that as NEDs would be working across two trusts he had concerns about the potential for dilution of assurance at his base trust.</p> <p>MS said that it is hoped that the level of information needed will be easier to source and as trusts work to make themselves slicker the need for the current level of oversight by NEDs will be diminished.</p> <p>The Deputy Chief Executive (JS) advised that the Executives had seen this as a positive development and were in favour.</p>	
	<p>The Board</p> <ul style="list-style-type: none"> • noted the draft principles and vision for the collaborative (in section 7), to be included in the statement of intent that will be presented for approval by the board in common. • approved the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (in section 10) 	

	<ul style="list-style-type: none"> • approved the proposed meeting structure for the collaborative (in section 10) • approved the process for the initial NED appointments (in section 12) • approved the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (in section 14) and, subject to agreement at the council of governors nominations and remuneration committee and the Council of Governors meeting, agree the changes to a minimum of 7 NEDs plus the chair and a maximum of 7 Executives • noted the next steps (in section 15) <p>MS also advised that the Medical Director (GA), the Director of Nursing (MVL), Catherine Jervis, Linda Burke and Janet Campbell had provided their support and approval for noting for the proposals.</p>	
ANY OTHER BUSINESS		
There was no other business to discuss.		
<u>Questions from Governors</u>		
The Lead Governor Tony Ellis asked:		
<ul style="list-style-type: none"> • Would the change to the Constitution ensure we maintained the majority of NEDs? DS advised that the proposals were that there would be a minimum of 7 Non-Executive Directors and the Chair and a maximum of 7 Executives. • Noting SMs point on dilution of NED assurance could we discuss further at the Nominations & Remuneration Council of Governors - committee taking place tomorrow. MS agreed, along with further discussion on a cycle, to ensure the NEDs provide visibility of the new committees to the Council of Governors. 		
<u>Questions from the Public</u>		
None.		
END		

1.3 Patient/Staff/Stakeholder Story

Discussion Item Speaker: Councillor Ketan Sheth / Carolyn Downs Time: 09.10

2. Report from the Chair in Common

Standing item Speaker: Chair in Common, Matthew Swindells Time: 09.20

- North West London Acute Provider Collaborative Statement of Intent

References:

- Enc 02. NWL Acute Collaborative Chairs Report 18.10.22 Final v3.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 2.0

This report is: Public

Report from the Chair in Common

Author: Matthew Swindells
Job title: Chair in Common

Accountable director: Matthew Swindells
Job title: Chair in Common

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the report.

Report history

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

N/A

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

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

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

Executive summary and key messages

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

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

1. Meeting Staff

2. As I have committed to since taking on the Chair in common role earlier this year, I have been on a number of visits and had the privilege to meet lots of staff across the breadth of our sites. My thanks as ever to the people who organised my visits and to the people who were so generous with their time in showing me their departments and services. Below is round up of some of the visits I have been on.
3. At **Hillingdon** I met with Kirsty Farrell, Clinical Services Manager & Trauma Service Lead to have a tour of the Emergency Department and I also met with members of the occupational therapy, pharmacy and integrated discharge teams. I accompanied Steve Barkley, then the Secretary of State for Health and Social Care when he visited for a tour at Hillingdon. I enjoyed being part of the Hillingdon Open Day last month where I got to meet staff (including staff from the Capitals Nepalese community) and members of the local community as well as receiving the gift from the Guild of Embroidery.
4. At **St Mary's** I had a tour of the Emergency Department and the Major Trauma service with Barbara Cleaver, Head of Specialty Emergency Medicine, joined a ward accreditation visit to the trauma Unit, and took part in a Schwartz round led by Alex King, Consultant Psychologist and was part of a Schwartz panel discussing being new at the trust.
5. At **Charing Cross** I visited the therapies and pharmacy departments, thanks to Ann Mounsey, Chief Pharmacist and Charlotte Allanby, Head of Adult Occupational Therapy for Physiotherapy for showing me around. I also attended the Summer Leadership Forum for staff at Imperial College Healthcare NHS Trust.
6. At **Northwick Park** I met with the Surgery Division and we walked around the operating theatres with Kevin Finlinson, Divisional Director of Operations, and Matthew Bartlett, Divisional Medical Director on the hottest day of the year. I also joined the senior leaders, as part of the Trust Board day, to have a tour of the Emergency Department and Same Day Emergency Care services.
7. At **Ealing Hospital** I met a number of the leadership team and had a tour of clinical areas, including Radiology and Endoscopy and I visited the planned site for the new Community Diagnostic Centre (CDC). I also attended a memorial tree planting funded by LNWH Charity. The hospital was the location for hit BBC drama 'This is going to hurt', written by former doctor Adam Kay. The tree has been planted in memory of NHS staff who have died by suicide.
8. At **Central Middlesex** I visited Gladstone 1 ward and the St Mark's Hospital. I also had the opportunity to talk meet with Mark Titcombe, Managing Director EOC, CMH & Ealing, Edgar Swart, Divisional Director of Nursing and Chloe Cox, Implementation Lead, Transformation Team to talk about the Elective Orthopaedic Centre and I also met with Evelyn Mensah, the clinical lead for ophthalmology to discuss outpatient plans.
9. I was also delighted to join the first part of the listening event for staff of **London North West University Healthcare NHS Trust** and attended the staff excellence awards ceremony.

10. At **West Middlesex**, I had a tour of the maternity ward with Mark Murphy, Head of Facilities and his team, I went to see the Acute Medical Unit and Ambulatory Emergency Care service team with Sanjay Krishnamoorthy, Service Director for Acute Medicine giving me a tour. I also had the opportunity to attend the Junior Doctors induction session and answered questions.
11. At **Chelsea and Westminster** I have visited a number of services, I had a guided tour of the Intensive Care Unit, visited the Planned Care Division, specifically the Treatment Centre and the Burns Unit, thanks to Nicola Rose and her team. I also attended the ChelWest Innovation Expo to celebrate its three year anniversary.
12. I am still working on visiting every site and meeting as many staff across all departments as I can. So, please, if you would like me to visit your department, please contact my office.

13. The Acute Collaborative

14. The four acute NHS trusts in North West London have formally come together under a single board in common. A lot of work has happened over the summer to move from four to one board. In July all four trust boards as well as NHS England approved the plans to move to work as an acute collaborative across North West London. During August we ran a Non-Executive Director (NED) appointment process and have appointed the 19 NEDs that will sit on the board in common. The new structures will build on the close partnership working that offered so many advantages to patients during the Covid-19 pandemic and will support us as we strive to recover services.
15. I would also like to take this opportunity to thank the outgoing non-executives directors, Ayesha Akbar (The Hillingdon Hospitals NHS Foundation Trust), Kay Boycott (Imperial College Healthcare NHS Trust), Beverley Ejimofo (Imperial College Healthcare NHS Trust), Eliza Hermaan (Chelsea & Westminster NHS Foundation Trust), Ben Maruthappu (Imperial College Healthcare NHS Trust), Andreas Raffel (Imperial College Healthcare NHS Trust), Andrew van Doorn (London North West University Healthcare NHS Trust) and Kingsley Peter (London North West University Healthcare NHS Trust).
16. Our clear challenge now is to take best of what we do and spread it across North West London. Please see the North West London Acute Provider Collaborative Statement of Intent, below in Annex 1. During September we have had our first Collaborative Committees, each are led by one of the Vice Chairs and one of the four Trust Chief Executives; i) Finance and Performance (Catherine Jervis and Lesley Watts), ii) Quality (Stephen Gill and Tim Orchard), iii) People (Janet Rubin and Pippa Nightingale) and iv) Infrastructure and Capital (Patricia Wright and Bob Alexander).
17. Pleased that by working together the four acute hospitals in North West London have collectively recovered their acute activity post Covid faster than any other sector in London and the shortest ambulance handover times of any sector. There is still a large amount to do to get waiting times and finances back to where we would want them to be. The advantage of our brilliant staff working together on behalf of local people is already there to see.

18. Elective Orthopaedic Centre (EOC)

19. We have this week gone out to public consultation on the Elective Orthopaedic Centre which we are proposing will be based at Central Middlesex Hospital, as we emerge from the pandemic with long waiting lists and many other pressing challenges, we want to draw on best practice from other areas and go further with our improvements. We want to bring together much of the routine, inpatient orthopaedic surgery for the population of North West London in a purpose-designed centre of excellence, completely separated from emergency care services.
20. The public consultation will run between Monday 17 October 2022 and Friday 20 January 2023 to get feedback on our proposal. We want to connect with as many people as possible across North West London, ensuring everyone has the chance to find out more, share their views and possibly get involved in the project.

21. Our Staff

22. I wanted to finish my report with a thank you to all staff across the four trusts, we have had one of the toughest summers in NHS history as we work hard to recover services. An example of staff's outstanding efforts was during the heatwave in July, clinical and non-clinical staff did brilliantly in caring for and treating patients, and in keeping them and staff safe, through the unprecedented temperatures seen during the heatwave. Especially considering that many of our facilities need capital investment, such as Hillingdon, St Mary's and Northwick Park, the dedication to keep services running safely was magnificent.
23. I have had the privilege of attending staff award ceremonies at London North West, Chelsea and Westminster and Hillingdon. It was great to see so many staff coming together to celebrate the successes across the trusts after several challenging years. Congratulations to all the winners and nominees, it was very inspiring to hear all the work and services that are being delivered across North West London. Thank you also to the staff and patients for taking the time to nominate staff, I know it was greatly appreciated.

North west London acute provider collaborative

Statement of Intent

Purpose

The purpose of this document is to set out a joint statement of intent across the four acute trusts in North West London – Chelsea and Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust – regarding the development of our acute provider collaborative. It includes the principles which we propose to use to guide the development and management of the collaborative.

Background

All NHS and care organisations in the eight boroughs of North West London have come together as the [North West London Integrated Care System](#) to deliver four key objectives, to:

- improve outcomes in population health and health care
- prevent ill health and tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader economic and social development.

As part of the wider NHS changes that led to the development of integrated care systems, there is also an expectation for trusts providing acute health services [to come together to form provider collaboratives](#) by April 2022. They will be a key component of system working, providing opportunities to improve care by working together effectively at scale.

Our vision for collaboration

We have developed increasingly effective partnership working arrangements in response to Covid-19 and this collaborative approach is helping us now as we emerge from the pandemic with the urgent need to restore planned care capacity and reduce waits and delays.

Our vision is to expand our collaboration to support sustainable improvements in all aspects of our work, for the benefit of our patients, local communities and staff. We believe we have all the elements to help create one of the best health systems in the world - a committed and diverse workforce, world-leading research and innovation and deepening relationships with our communities and stakeholders. If we share and embed the best of what we see across our hospitals – in terms of ways of working, outcomes and experience – we have the potential to do something extraordinary.

In particular, we want our provider collaborative to:

- make the most of our collective resources, ensuring we provide high quality care as quickly as possible according to clinical need
- achieve continuous improvements in quality, efficiency and outcomes by supporting each other to identify, adopt and embed best practice
- proactively tackle unwarranted variations and inequalities in access and experience
- make better, collective use of our corporate and clinical support services
- promote the development of alliances and networks at all levels to support the development of more joined up care between and within specialties
- ensure our hospitals attract and retain excellent staff by fostering a supportive and inclusive working culture with a commitment to learning and development, health and wellbeing
- develop care models and care pathways that better meet the needs of our patients and communities, ensuring we understand and respond to views of all our users
- achieve more rapid and consistent spread of innovation, research and technology.

We want patients to be at the heart of everything we do and, further, to actively benefit the health and wellbeing of our local communities. We are committed to providing the best possible care to patients irrespective of age, disability, religion, race, gender or sexual orientation, ensuring that our services are accessible to all but tailored to the individual.

We will establish governance arrangements that enable us to reach joint decisions effectively and efficiently, which each partner is then committed to upholding. These arrangements will also enable us to hold each other to account, ensuring that decisions are implemented and benefits are realised.

Key principles of collaboration

In developing and managing the collaborative, we will draw on the following principles:

- a commitment to delivering a step change in quality and financial and operational performance across our system
- a commitment to treat everyone fairly and inclusively
- maximising the benefit of our collective resources by improving coordination and avoiding duplication
- collective decision-making for the benefit of our patients, communities and staff
- transparency of our data, information and decisions
- a commitment to join up our strategies and planning
- respect for the continuing statutory roles of our respective trust boards and councils of governors (in the case of foundation trusts).

Chelsea and Westminster NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

Imperial College Healthcare NHS Trust

London North West University Healthcare NHS Trust

2.1 Chief Executive Officers' Reports

Discussion Item Speaker: Chief Executive Officers, Lesley Watts, Patricia Wright, Tim Orchard, Pippa Nightingale Time: 09.30

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

References:

- Enc 03 a. NWL BiC CEO Reports coversheet - October2022 v2.pdf
- Enc 03 b. CWFT CEO Report_Public_Final.pdf
- Enc 03 c. ICHT CEO Board Report - October 2022 v1.2.pdf
- Enc 03 d. LNWH CEO report BiC October 2022 v2.pdf
- Enc 03 e. THHFT CEO Report_October2022_V3.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 2.1

This report is: Public

Chief Executive Officers' Reports

Author: Tim Orchard, CEO ICHT, Pippa Nightingale, CEO LNWH, Lesley Watts, CEO CWFT and Patricia Wright, CEO THHFT

Job title: Chief Executive Officers

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

Job title: Chief Executive Officers

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the reports.

Report history

N/A

Executive summary and key messages

This report provides an update from the Chief Executives of each of the four trusts in the north west London acute provider collaborative (Chelsea & Westminster NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust) on key issues relating to each respective trust.

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

Strategic priorities

Tick all that apply

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

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

Impact assessment

Tick all that apply

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

Reason for private submission

Tick all that apply

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

N/A

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

Accountable director: Lesley Watts
Job title: Chief Executive Officer

Executive summary and key messages

National Moment of Reflection

At 8pm on 18 September, staff and members of the public gathered outside our hospitals for one minute's silence to mourn the passing of Her Majesty Queen Elizabeth II. This was an opportunity to reflect on her life and legacy, and the impact she had on our lives. The Queen officially opened the doors of Chelsea and Westminster Hospital in 1993 and we will be forever grateful for her support to our organisation and the work of the NHS.

The State Funeral presented us with operational challenges due to road closures around our Chelsea site. I would like to commend all staff involved in preparations for the bank holiday weekend, and those who helped keep essential clinical services running for our patients—it was a truly impressive effort.

The North West London Acute Collaborative

The North West London Acute Collaborative was formally established on 1 September 2022 and appointed Matthew Swindells as its single Chair for its four acute Trusts – Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust.

Prior to September, the four organisations had already established closer partnership working through a joint Acute Care Board, set up in March 2021 after the COVID-19 pandemic demonstrated the positive impact of greater collaboration. The Acute Collaborative works to make the best possible use of the four Trusts' collective resources and to offer patients consistent high-quality care and a more 'joined up' experience. The move follows similar collaboratives across the country and reflects wider NHS policy, with endorsements to this approach from NHS England and Improvement and relevant Trusts' councils of governors.

Ready for Winter

The Trust is launching a major call to action ahead of winter this year. The Ready for Winter programme sets out an organisation-wide series of arrangements for ensuring service delivery throughout winter 2022/23. The winter period sees an increase in emergency and non-elective demand and increased clinical acuity of patients, resulting in increased pressure on patient flow and hospital resources. The winter plan follows guidance from NHS England in terms of content and approach and recognises key risks to patient care, safety and experience, as well as to the organisation. Plans are underway to optimise a number of front door schemes and inpatient flow to support. We will be working closely with colleagues within the Acute Collaborative and ICB for a consistent NW London approach.

Staff Awards

After three long years and months of anticipation, we celebrated our Staff Awards on 21 September at the Science Museum. It was an inspirational evening as we recognised the achievements of our staff during these challenging years. I would like to congratulate our winners and nominees, and hope all who attended enjoyed the evening. Thank you to our colleagues and patients for taking the time to nominate staff who made a difference and showed what it means to be unfailingly kind—we received a record 1,066 nominations. Thank you also to our charity CW+, who kindly supported the event, and to all involved in the preparations—it was a spectacular tribute to our staff.

CW Innovation event

I was delighted to attend the CW Innovation event on 21 September at our Chelsea site which brought together NHS and industry leaders to share learning and future ambitions. Speakers included NHS England's National Director of Transformation Dr Tim Ferris and National Clinical Director for Innovation Professor Tony Young, alongside our Chair Matthew Swindells, partner representatives and our own clinicians.

The CW Innovation programme, jointly led by our Trust and CW+, has been running for three years, with a portfolio of more than 80 projects. The programme provides funding for innovative and entrepreneurial staff to realise their ideas to improve patient care. The programme has generated national recognition for the Trust as a leader in innovation, supporting the wider NHS.

Monkeypox and sexual health services

The Trust is recognised as a national leader in monkeypox and our research has attracted international media coverage from New York to Australia. Minister for Vaccines Maggie Throup visited 10 Hammersmith Broadway learn about our monkeypox vaccination programme which prioritises those who are most at risk. We are part of new national trial for fractional vaccine dosing to stretch supplies to more people.

The all-party parliamentary group (AGGP) on HIV and AIDS visited Dean Street to learn about our work in monkeypox and sexual health, and to understand the unique pressures faced by our sexual health services.

Staff from *Gay Times* visited Dean Street Express to highlight the ease of using our leading sexual health services, promoting testing on their social media channels which reach a combined 1.5 million followers. Work is underway to create educational content in collaboration with *Gay Times* for their audience base.

Chelsea and Westminster Hospital and West Middlesex University Hospital

1 September marked seven years since Chelsea and Westminster Hospital joined forces with West Middlesex University Hospital to become one organisation. It took three years of careful planning to execute this merger, uniting two hospitals with centuries of history. Combining our expertise, we have been able to delivery world-leading patient care locally and we continue to attract a talented workforce of 6,500 staff. Much has been achieved in these years—launching our cardiac catheter lab, redeveloping our A&Es, AECs and critical care services, achieving the lowest mortality rate nationally, relaunching our Trust values and refurbishing many of our wards. Our workforce has strengthened by two thousand in this period, and the CQC have awarded us 'outstanding' and 'good' across all our services. This wouldn't have been possible without our staff who make our organisation one of the best performing Trusts in the country.

Our West Mid site was named National Joint Registry Quality Data Provider for 2021/22, recognising our high standard of care—the registry provides data to monitor orthopaedic procedures, which is used to benefit patients and to advise manufacturers.

Financial wellbeing

I am conscious of the rising cost of living and energy costs affecting us all, and the Trust is doing everything we can to make staff feel supported. An all-staff webinar about financial wellbeing was hosted on 13 September.

Other highlights

- **HIV opt-out testing:** Following a successful trial in our A&Es—where all patients requiring blood tests are now tested for HIV unless they specifically opt out—HIV opt-out testing has been rolled out London-wide. Last year, 66% of new HIV diagnoses at West Mid originated from tests in A&E.
- **Chelsea Centre for Gender Surgery:** We are the first Trust to be commissioned by NHS England to carry out masculinising lower surgery. A major programme of work is underway to prepare for this service working very closely with NHS England.
- **Diagnostic waiting times performance:** Our imaging service was named as one of the top performing Trusts in the country for diagnostic waiting times performance by NHS Digital.
- **Vaccinations:** Following the launch of our COVID-19 booster campaign, all staff can book in for their vaccinations and boosters at both hospital sites. At West Mid we are also offering vaccinations and boosters to members of the public who are aged 50+ and/or immunosuppressed. We will be launching our flu vaccination campaign once vaccines are available.
- **Official opening of CW Medicines:** Our new outpatient pharmacy CW Medicines Ltd, a subsidiary company of the Trust, officially opened on 23 August, replacing the previous service run by Boots. The new pharmacy foregoes retail sales to focus on efficiently filling prescriptions for our patients.
- **Annual Members' Meeting:** We held our Annual Members' Meeting on 21 July 2022. Thank you to all staff involved in preparing the Annual Report and Accounts and to all who joined the meeting.

The Trust Board and I continue to be incredibly grateful for the extraordinary efforts that each and every one of our colleagues is making—our organisation is outstanding because of our people. In concluding this report I would like to say how very proud I am of our Trust and how we would not be able to achieve the results described above without the fantastic team that is Chelwest.

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

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

Executive summary and key messages

1. Changes to Board composition

- 1.1 I would like to take this opportunity to give a warm welcome Linda Burke, Aman Dalvi, David Moss and Janet Rubin who joined our Board, as non-executive directors, on 1 September 2022.
- 1.2 I would also like to pass on my sincere thanks to Andreas Raffel and Kay Boycott, Non-Executive Directors and Ben Maruthappu and Beverley Ejimofu, Associate Non-Executive Directors, who have stepped down as non-executive directors, for their time and significant contributions to the Trust.

2. Operational performance

- 2.1 Covid-19 continues to be a factor within our hospitals. Admissions spiked during the summer exactly when predicted (148 positive cases on admission across all sites on 8th July), but since that time have continued to decrease, and the number of patients requiring treatment in our intensive care units or requiring a ventilator has stayed consistently low. Our robust infection prevention and control measures continue to ensure patient and staff safety, and the requirement to wear a surgical mask around any inpatient area or clinical treatment room remains in place.
- 2.2 Continuing higher levels of staff sickness and vacancies, coupled with the challenges of returning to pre-pandemic levels of elective activity, mean our services remain under pressure across all sites. As of July, the Trust was at 88.9 per cent of its overall pre-pandemic planned care activity, 130.8 per cent of its pre-pandemic outpatient activity, and 97.6 per cent of its total pre-pandemic diagnostic testing. Overall, this delivered 106.4% of value weighted activity. We are committed to delivering over 100 per cent of overall pre-pandemic planned care capacity throughout 2022/23 to help us achieve a sustainable reduction in waiting times. As none of our patients are waiting over 104 weeks for care, we continue to focus on ending other long waits. Additionally, the Trust has continued to maintain some of the shortest ambulance handover times in London. I am enormously grateful to our staff for their unwavering dedication and flexibility during this sustained period of demand and pressure, to ensure that we deliver the best possible care for our patients and population.
- 2.3 We have also focused on improving performance against the 62 day cancer waiting time standard and I am pleased to report that with concerted effort over the last few weeks the team have managed to reduce the backlog very significantly, and we are no longer an outlier. We are continuing to focus on this area to eliminate 62 waits completely as soon as possible.

2.4 The Trust is already experiencing some of the pressures normally associated with winter, with emergency admissions rising earlier on in the year than previously witnessed. However, the Trust began its winter planning preparations much earlier this year, with a series of winter funding packages agreed in September that will help to alleviate staffing pressures by allowing for earlier recruitment. The Trust also hosted its winter workshop in September in order to reaffirm the proper escalations and procedures when sites experience excessive pressure; this operational governance will be a key line in keeping patients safe throughout the pressures of this coming winter.

3. Covid-19 and flu vaccination programme

3.1. The Trust vaccination programme reached another milestone on 29 September as we administered the 90,000th Covid-19 dose since the programme began in December 2020. The 2022 vaccination programme was launched in September and in the first three weeks 11% of substantive staff have received their Covid-19 seasonal booster, compared with the London average of 8.9%. 83% of staff who have received a Covid-19 booster also received their flu vaccine at the same time.

3.2 A limited number of appointments at Hammersmith and Charing Cross vaccination centres have been made available for patients to book via the national booking system (NBS). We will continue to monitor staff appointment uptake levels and allocate capacity to NBS where possible. The inpatient boosters vaccination service has also commenced, supported by the site nurse practitioners.

3.3 The St Mary's site has been approved for the administration of Nuvaxovid (Novavax) vaccine, for those patients with severe allergic reactions to mRNA vaccines or its components, such as Polyethylene Glycol PEG. A referral systems has been set up with GP practices in North West London.

4. Financial performance

4.1 The Trust has set a plan to break even in the financial year 2022/23 (April 2022 - March 2023). This plan depends on achievement of a £37m efficiency programme and achievement of elective service recovery funding (ESRF) for meeting 104% of 2019/20 activity on a value weighted basis.

4.2 The Trust's financial systems were affected by the national systems outage during August. Trust teams deployed manual business continuity processes to ensure: the impact on operational performance was minimised as far as possible; goods and services could continue to be ordered; urgent payments to suppliers could be transacted and month 5 reporting was available. Systems were reconnected in September and normal processes are now in place.

4.3 For the first five months of the financial year (April - August 2022), the Trust reported a £13m deficit. The main driver of this shortfall is under delivery of the efficiency programme of £13m against an equally phased plan, with the additional cost pressures in both theatres and critical care (sickness and vacancies) offset by additional ERF income linked to the achievement of 106.4% of value weighted 2019/20 elective activity. The Trust expects to meet the breakeven plan for the year and has identified the actions required to achieve this.

4.4 At month five the capital programme for the year is £130.4m, of which £106.1m counts towards the Trust Capital Resource Limit (CRL). Expenditure against the CRL at month 5 totalled £19.8m (against a plan of £25.4m).

4.5 The Trust had a higher than planned cash balance of £258m at 31 August 2022. This is expected to return to expected levels once the Trust has transacted the payments not actioned during the system outage. This value represents an increase of £20.6m from the start of the year.

5. Maternity assurance

5.1. The Trust provides oversight of quality assurance within the maternity service via a maternity quality oversight assurance report to each Quality Committee meeting.

5.2 Due to ongoing staffing pressures, Imperial maternity is being supported by Chelsea and Westminster Hospital and their contracted Independent Midwives to provide an interim homebirth service until November. A proposal has been submitted to north west London Local Maternity and Neonatal System (LMNS) with a view to implementing a sector wide homebirth service.

5.3 The Trust underwent its Ockenden Assurance Visit on Wednesday 28 September. We await the draft report from this assurance visit. We also continue to support in preparation for the impending CQC inspection.

5.4 The Maternity Directorate has a current vacancy rate of 14% and a sickness rate of 6%. There has also been an increase in the turnover rate for the month of September to 17.5%. Discussions are in progress to review the expansion of the senior leadership structure within maternity to provide additional operational and strategic support.

5.5 Imperial Maternity Voice Partnership (MVP) have completed a structured 15 steps walk around at St. Mary's Hospital and Queen Charlotte's & Chelsea Hospital (QCCH), and an action plan developed to address recommendations.

6. CQC update

6.1. The CQC continues to investigate an incident that occurred in September 2020, involving a patient with mental health needs in the ED at St. Mary's Hospital. In August 2022, the Trust was advised that the CQC's internal panel had not reached a decision about whether to proceed or close the investigation and is now seeking external legal advice; we have been told there is no estimated timeline for this advice to be received or for a decision to be reached.

6.2 During its routine engagement with the Trust, the CQC continues to indicate that overall the Trust continues to be considered low risk compared to other trusts. This means that the Trust is not expected to be prioritised for routine inspection in the current financial year. However, in July 2022, the CQC announced a national programme of maternity inspections for all services last inspected before April 2021, which includes the Trust (maternity services were last inspected in February 2019). The CQC aims to deliver this programme in the current financial year, which means the Trust expects its maternity services to be inspected by the CQC sometime before April 2023.

6.3 The Trust's Improving Care Programme Group (ICPG) 'back to basics' peer review programme has been underway since April 2022. Five peer reviews have now been completed; A&E, diagnostic imaging, cancer services, maternity and main outpatients.

7. Redevelopment update

7.1 The Trust has completed work looking at options for the delivery of a new hospital at St Mary's. The next steps are dependent on the national New Hospital Programme team progressing the Programme Business case. We have regular engagement with the national team and are working with them to progress the Strategic Outline Case.

7.2. The master planning work on the Charing Cross and Hammersmith sites has identified a short list of master plan options. This has been identified following workshops and engagement with clinical and site operational teams. The next step is to look in detail at the short listed options and identify the preferred option. The Trust is meeting with the national New Hospital team in October to progress the business cases for these sites.

8. Paddington Life Sciences

8.1 Plans to develop a cluster of life sciences activities in Paddington connecting to research and innovation at St Mary's Hospital have been shared and a new Trust website has been launched - the website details the key initiatives that are already underway. <https://www.imperial.nhs.uk/paddington-life-sciences>. Paddington Life Sciences draws on deepening relationships between the Trust and research, industry and community organisations. As well as setting out the longer term vision for Paddington Life Sciences, involving the planned redevelopment of the whole of the St Mary's site. The team has progressed the Digital Collaboration Space which is now operational and the second meeting of the Paddington Life Sciences Partnership has been arranged.

9. Research update

9.1 Although still awaiting formal notification and contract from the Department for Health and Social Care (DHSC) on our Biomedical Research Centre (BRC) award for the next 5 years, we have begun the process of internal budgeting and planning with the themes and core facilities. This is with a view to being able to seamlessly continue existing posts and start new workstreams on time. The Finance team are fully engaged, and a communications plan is prepped. We have many challenging BRC objectives to deliver over the next 5 years - it will be important we hit the ground running and have the support structures in place to do so.

9.2 A recent important output from the existing BRC was published recently in the International Journal of Cardiology, with authors from across the Trust and the College, and in collaboration with Oxford, Bristol, UCL, Guy's and others. This paper presents the results of a multi-centre study which investigated the interaction between the extent of damage to the heart following a heart attack – as indicated by the levels of the important protein known as troponin, and the optimal time to carry out surgery. The team used patient data collected through the NIHR Health Informatics Collaborative and BRC infrastructure and found that doctors can improve the timing of surgery for heart attack treatment options patients by analysing the levels of troponin in the blood.

9.3 A recently published study (Lancet Respiratory Medicine), funded by NIHR and supported by the NIHR Imperial Biomedical Research Centre, analysed data to assess the window of COVID-19 infectiousness in a real-world community setting, a crucial topic which has not received extensive research attention. The study recruited 738 participants from 542 households who underwent self-performed daily upper respiratory tract (URT) swabs for up to 20 days, to enable testing. The results revealed that, on average, COVID-19 infected people were infectious for five days. Although some participants tested positive via a PCR test before developing COVID-19 symptoms, this does not confirm that those people were infectious. Only one in five participants was infectious before symptom onset. Most people only became infectious after developing symptoms. The study adds further evidence to enable policymakers and the public to adapt or minimise the self-isolation periods to match the duration of infectiousness given the societal, psychological and economic costs of self-isolating for longer than is required.

9.4 Early discussions have taken place with potential partner organisations across North London to consider how to respond to the recent announcement from DHSC for hosting the next 5-year contract for the National Institute for Health Research (NIHR) Regional

Research Delivery Networks (RRDNs). These are the latest iteration of the existing NIHR Clinical Research Networks.

- 9.5 A number of potential improvements have been developed in relation to the processes, structures and functions of the existing research and development support infrastructure in the Trust, including the Joint Research Office and divisional research management. This was following a wide internal consultation and review of other similar NHS Trusts. The main aim is to streamline the research and development set-up processes so that we are one of the quickest in the country, but also to be able to grow commercial trials activity, underpin the new BRC objectives, and support the innovation agenda.

10. Equality, Diversity and Inclusion (EDI) update

- 10.1 We have produced our EDI Workforce Annual Report, as part of our Public Sector Equality Duty (PSED), which includes our workforce race equality standard and our workforce disability equality standard.

- 10.2 Our EDI Workforce Annual Report outlines a number of initiatives and areas of progress in 2021/22, including:

- Developing our staff
- Improving our HR policies
- Improving the accuracy, quality and use of diversity data
- Leadership development
- De-biasing HR processes, particularly in recruitment and managing conduct
- Growing and supporting our staff networks
- Our internship programme for young adults with learning difficulties
- Extending apprenticeships and work placements
- Increasing and participation in well-being initiatives with an EDI focus
- Expanding accreditations and membership of expert / advisory bodies

- 10.3 We acknowledge that we have come a long way in the last two years - in spite, as well as because, of Covid however recognise we have a long way to go to reach our goals for the workforce and workplace we want to see.

- 10.4 The creation of a dedicated EDI team has helped increase the speed of progress and our staff networks are growing in size and stature with the committed leadership of their chairs and their executive sponsors. We are committed to building on this momentum to implement the solid plans we have in place.

11. Stakeholder engagement

- 11.1 Below is a summary of significant meetings and communications with key stakeholders:
- North West London Joint Health Overview and Scrutiny Committee: 20 July 2022
 - Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith: 25 July 2022
 - Cllr Ketan Sheth, London Borough of Brent: 9 August 2022
 - Cllr Angela Piddock, Westminster City Council: 23 August 2022
 - Communication to all NW London local authorities on behalf of acute provider collaborative with update on the proposal for north west London elective orthopaedic centre: 21 September 2022.

12. Recognition and celebrating success

- 12.1 I am pleased to report that Imperial College Healthcare has won Trust of the Year in the NHS England London Healthcare Support Worker Programme awards which recognises the commitment of healthcare support workers to provide high standards of nursing and

midwifery care. Congratulations also to Lizabeth Rudloff and Salini Sivankutty from haematology outpatients at Hammersmith Hospital who were shortlisted for Healthcare Support Worker of the Year.

12.2 I am also delighted that the Trust has been shortlisted in five categories for this year's national Healthcare Service Journal (HSJ) awards, recognising outstanding contribution to healthcare.

- Trust of the year
- Military and Civilian Health Partnership
- Primary and Community Care Innovation of the Year
- Digitising Patient Care
- Driving Efficiency through Technology.

12.3 We congratulate Trust clinicians who have been awarded academic promotions by Imperial College London in the annual round of promotions:

Ramzi Khamis, Reader in Cardiology

Claire Shovlin, Professor of Practice (Clinical and molecular medicine)

Richard Gibbs, Professor of Practice (Vascular surgery)

Harpreet Wasan, Professor of Practice (Medical oncology)

Anthony Goldstone, Reader in PsychoNeuro Endocrinology

Paresh Malhotra, Professor of Clinical Neurology

Michelle Willicombe, Clinical Reader in Transplantation

Aubrey Cunnington, Professor of Paediatric Infectious Disease

Richard Smith, Professor of Practice

12.4 Two of seven new community diagnostic centres announced by NHS England this week will be run by the Trust. Our centres, in Willesden and Wembley, will enable us to offer more 'one stop' appointments for a range of diagnostic checks, scans and tests. The locations of the centres have been carefully selected to help us tackle health inequalities and improve access. Our centres will act as 'spokes' to a larger, third community diagnostic centre that has already been announced that will be run by London North West University Healthcare NHS Trust and located on the Ealing Hospital site.

12.5 Charing Cross Hospital overcame a significant hurdle in efforts to reduce its carbon footprint earlier this month, with the assistance of a rare 450 tonne mobile crane. The giant crane, one of only four of its type in the UK, enabled the team to lift and install two heat pumps on the roof of the hospital's 68 metre tower block.

12.6 A new state-of-the-art CT scanner is being introduced at Charing Cross Hospital from Saturday 17 September, replacing the current 12-year-old scanner. The work will take 17 weeks (completing early January 2023) and during this period some outpatient work will move to St Mary's and Hammersmith hospitals and to Alliance Medical, meaning there will be no loss of CT capacity. On-site and remote IT support for the scanner will be available for the duration of the programme.

12.7 The Trust has been given the go ahead to a major £9m building project at Western Eye Hospital, allowing us to reopen the hospital fully next spring. As well as the remedial works to address the fire safety issues that led us to take the precautionary step of closing some parts of the hospital last year, the project will deliver an additional operating theatre (bringing the total to three) and refurbish pre-assessment and pre / post operation areas.

Chief Executive Officer's Report – London North West Hospitals NHS Trust

Accountable director: Pippa Nightingale
Job title: Chief Executive Officer

Executive summary and key messages

1. Welcoming new colleagues

- 1.1 We are delighted to welcome several new colleagues to LNWH's board.
- 1.2 Tracey Connage, our new Chief People Officer, joined our executive team in September, having previously held the Director of Human Resources and Organisational Development role at Harrow Council.
- 1.3 We also greeted four non-executive directors last month: Bob Alexander, Ajay Mehta, Simon Morris and Sim Scavazza.
- 1.4 I would also like to thank our outgoing non-executives. Andrew van Doorn leaves us to take up a non-executive role at Hertfordshire Partnership University NHS Foundation Trust, while Neville Manuel has joined the boards of The Hillingdon Hospitals NHS Foundation Trust and Chelsea and Westminster NHS Foundation Trust. We remain enormously grateful for all their advice and support over the last few years.

2. Operational performance and recovery

- 2.1 At end of September, we achieved a significant milestone with no people waiting for 104 weeks or more on our referral to treatment pathway.
- 2.2 We continue to increase capacity and remain over 2019-20 baseline levels. However, we are yet to fully achieve our intentions to deliver 120% for first outpatient appointments and 107% for planned care.
- 2.3 Currently, we are delivering 104% against our baseline for first outpatient appointments. In addition to actively booking more patients into our clinics, we are focussing on improving our processes and our communication with patients to reduce 'did not attend' rates. Work is ongoing to create more capacity while also improving patient experience through the patient initiated follow up process.
- 2.4 We are delivering 102% against our baseline for planned care. Work continues to improve booking processes for a range of elective areas, which in turn will reduce on the day cancellations and improve theatre productivity. We are also increasing our number of theatre lists.

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- 2.5 Both emergency departments remain extremely busy, at close to winter levels. In partnership with the London Ambulance Service, we are developing postcode redirection schemes to ensure that ambulances are distributed at safe levels between Ealing and Northwick Park, and at our neighbouring hospitals.
- 2.6 At the time of writing, our Covid position is stable at a relatively low rate, but we will continue to monitor this situation closely throughout the winter.

3. Covid-19 and flu vaccination campaign

- 3.1 We began our Covid-19 and flu vaccination campaign in September.
- 3.2 Colleagues are being urged to have their vaccinations as soon as possible to protect one another as well as vulnerable patients.
- 3.3 This year's campaign is headed "Better together: don't let infections push us apart" and features colleagues and patients interacting together across our organisation.
- 3.4 Our team have already given more than 1,000 doses of Covid-19 booster vaccines in just three weeks, and we look forward to continuing this positive start.

4. Financial performance

- 4.1 We have continued focus and scrutiny to ensure we meet our financial plan. There are three key areas of enhanced scrutiny: elective recovery funding, cost improvement, and inflation and operational pressures.
- 4.2 As outlined in the operational summary, we continue to deliver activity levels below the required threshold, despite recent improvements. However, we are having ongoing discussions regarding the allocation of elective recovery funding for Q1 and 2 with the ICB, and this position may change. We are focussing on delivering ERF thresholds for Q3 and 4 through the recovery delivery group.
- 4.3 Cost improvement plans (including transformation scheme benefits) are forecasting delivery at about £21m of our £30m target. The CFO is working with divisional teams and executive directors to review opportunities to improve this position.
- 4.4 In addition, increased emergency activity, coupled with significant cost increases for drugs and clinical supplies, are driving a series of cost pressures adversely impacting the financial position. We are seeking to identify sources of secure alternative funding; in the meantime we continue to work closely with colleagues in procurement to maximise reductions in cost within the current financial year.
- 4.5 As a result of all these factors, we are preparing a revised forecast for the finance and performance committee, in conjunction with partners across the acute collaborative and the ICB.

5. Ockenden assurance visit

- 5.1 In August, the Trust hosted an assurance visit in relation to the Ockenden report. These assurance visits, which are taking place at every NHS maternity department, consist of a presentation, followed by a series of interviews and observations.

- 5.2 We were pleased that the Ockenden team recognised the extremely hard work of the team, and the important support offered by the ICB and the maternity safety support programme.
- 5.3 The visitors described big improvements in the culture of the department and observed that the leadership team were well known and valued by colleagues. They also praised the good information offered to women and birthing people, with a particular emphasis on interpretation.
- 5.4 They agreed with our identified areas of improvement, including further developing our training, our community midwifery model, and improving the cultural sensitivity of our care. They also recognised the challenges we experience around workforce, which are reflected nationwide.
- 5.5 We were perhaps most pleased that the visitors acknowledged our focus on improvement and sustainability, as we continue to work towards offering outstanding maternity care for our communities.

6. Our Way Forward: progress update

- 6.1 Work continues to develop Our Way Forward, a new five-year strategy for LNWH.
- 6.2 Engagement with employees, stakeholders and our communities has formed a core part of our activity to date, incorporating in-person events at each of our three boroughs, multilingual online surveys, and a series of online events.
- 6.3 To date:
- 77 people have attended our in-person forums
 - 781 people have completed our community survey
 - we have received 2,118 inputs from employees.
- 6.4 We have monitored both employee and community engagement carefully to check that it is as representative of our communities as possible, including monitoring both by age and ethnicity, and have been pleased to see a close correlation in both cases.
- 6.5 In addition, the team have undertaken a vast amount of analysis of public health, demographic, and other data relating to our local communities, as well as our own data and best practice case studies, offering us vital context.
- 6.6 Work is now underway to produce the strategy itself, informed by this engagement and analysis.

7. Stakeholder relations and events

- 7.1 In the summer, I joined the North West London Residents' Forum to discuss the elective orthopaedic centre. We appreciate the useful insights offered by the participants.
- 7.2 In August, we welcomed the author Adam Kay, Amandip Sidhu, founder of charity Doctors in Distress, and Jennie Barnes, representing the Laura Hyde Foundation, to Ealing Hospital for a tree planting in memory of healthcare workers who have died by suicide. NHS Medical Director Prof. Stephen Powis also spoke at the event,

which was attended by many of our local and regional partners and stakeholders as well as employees from across the north west London NHS. The commemorative event helped to raise awareness of mental health in NHS and other healthcare workers. It also offered an opportunity to highlight the help available for colleagues who need it, and once again, I urge anyone who may need support to talk to someone.

7.3 We were delighted to welcome Cllr Daniel Crawford, Chair of the Health and Adult Social Services Standing Scrutiny Panel, and Cllr Andrew Steed to Ealing Hospital on 1 September. They met with Deputy Chief Executive Simon Crawford, Mark Titcomb, Managing Director for Central Middlesex and Ealing hospitals and Dr Miriam Harris, Divisional Medical Director. The councilors also met staff on several wards and departments including the Same Day Emergency Care unit and heard about plans for the Community Diagnostic Centre at Ealing.

8. Congratulations and good luck

8.1 Several colleagues have been shortlisted for Nursing Times awards:

- Our learning and OD and recruitment team (specifically those colleagues responsible for recruiting and providing support for new nurses) are shortlisted for employer of the year for nursing staff
- Consultant nurse Zarah Perry-Woodford is shortlisted for clinical manager of the year
- Pre-registration nursing and CapitalNurse lead Caroline Foley is shortlisted for non-clinical manager of the year.

8.2 In addition, our remote monitoring heart failure service has been nominated for the international Luscinia Award. The service allows heart failure patients to self-monitor their condition at home using an app. It has significantly reduced unnecessary appointments, allows the team to optimise their patients' care, and as a result has led to improvements in both clinical outcomes and patient satisfaction.

8.3 We wish all our colleagues the very best of luck.

8.4 I congratulate our pharmacy team, who in partnership with firm Written Medicine, were highly commended in the 'innovation helping address health inequalities' category at the AHSN Innovate Awards. The teams were nominated for their work on bilingual medicine labels to reduce language barriers.

8.5 Finally, I would like to congratulate volunteer Beryl Carr, who has been voted one of the 50 happiest Britons in The Independent newspaper's Happy List. Beryl remains a volunteer for The Friends' Café at Ealing Hospital at the extraordinary age of 100.

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. Trust Open Day

- 1.1 On Saturday 24 September, the Trust held an Open Day at Hillingdon Hospital to give an informative insight into our work. Our local community, staff and key stakeholders were invited to attend from 10am-3pm, to see what we do and how we do it; to learn more about our services and skills and to meet the people who deliver excellent care to our patients. The Education Centre was full with everything from displays about the work of the tissue viability service to resuscitation, from speech and language therapy to nurse education, from stroke care to research and development. Tours of theatres were offered and a BBQ was available for all at lunchtime.
- 1.2 The day was an opportunity to re-connect with the public after the pandemic. Many members of staff also said how delighted they were to be able to meet with colleagues and share information about their work.

2. Embroidery panels

- 2.1 A highlight of the Open Day was the unveiling of a beautiful gift from the Embroiderers' Guild.
- 2.2 Members of the Guild were asked to embroider a 10cm finished square of fabric to convey their own message of thanks to the NHS for its efforts during the Covid-19 pandemic. Dozens of individual squares have been joined together to form three unique, separate framed panels, which the Guild have gifted to the NHS. The Trust is delighted to be able to host these panels on behalf of the NHS. Two of panels will be on display at Hillingdon with the third at Mount Vernon.
- 2.3 The panels were received on behalf of the Trust by Matthew Swindells (Chair in Common), Patricia Wright (CEO) and Melanie van Limborgh (Director of Nursing). The Trust was sent a personal message of congratulation from The Rt Hon Boris Johnson, MP for Uxbridge and South Ruislip which was read out at the unveiling ceremony during the Open Day. He said: 'As the MP for Uxbridge and South Ruislip I have had the honour of visiting Hillingdon Hospital many times over the years, and have seen first-hand the dedication, care and love exhibited by the staff – not only for the hospital and its patients, but for the NHS itself.'

3. Covid-19 booster hub open

- 3.1 On Tuesday 20 September, the Hillingdon Hospitals NHS Foundation Trust opened its doors once again to offer Covid-19 boosters to staff and the public who are eligible. The NWL Acute Provider Collaborative's Chair in Common, Matthew Swindells, took the opportunity during the Trust's Open Day to walk in and have his booster vaccine.

4. Annual Members' Meeting

- 4.1 The Hillingdon Hospitals NHS Foundation Trust's Annual Members' Meeting took place on Tuesday 20 September, which gave staff and the general public an opportunity to look back at the past year at the Trust and to events and developments to come over the next financial year. Trust CEO, Patricia Wright, updated members on the many achievements and success stories of 2021-22 whilst noting continued pressures on finance and performance, and looked ahead to key developments to come, such as the Acute Care Collaborative. There were also updates on key themes such as finance, performance and the redevelopment of Hillingdon Hospital. Lead Governor, Tony Ellis, provided a report on the role of Governors and on membership issues.

5. Hospital Redevelopment - work continues

- 5.1 At a national level the Redevelopment Team are working closely with the New Hospitals Programme in the development of the programme plans for the next generation of hospitals. At a local level, the Local Authority are in the process of reviewing the planning application for the new Hillingdon Hospital, and the Redevelopment Team are working closely with local stakeholders through the review process. At a Trust level the proposals on the next phase of the Trust's enabling and decant programme were approved by the Trust.

6. The Trust's strategy

- 6.1 The Trust's revised strategy document has been approved. A short summary is being designed and both will be published in the near future.

7. Podcasts continue to be popular

- 7.1 The Communications and Engagement Team continue to meet with colleagues to record short podcast episodes on topical information and news. During September our podcast series received almost 500 new downloads with our menopause episode remaining the most popular (all time).

8. Awards

Sustainability Team

- 8.1 The Trust's Sustainability Team have been shortlisted for two award categories at the National Sustainability Awards - one for the Transformation Award and also one for Partnership of the Year Award (with HATS). Winner to be announced on Thursday 6 October 2022. The team have also been shortlisted for the HSJ Awards 2022 (Towards Net Zero category).

Advice and Guidance

- 8.2 Advice and Guidance was shortlisted as a finalist for the Innovation Spread Category for the Innovate Healthcare Awards 2022 for the ongoing work with GPs to treat eligible patients in the community instead of within an acute hospital setting.

3. NWL Acute Provider Collaborative Scheme of Delegation

Decision Item Speaker: David Searle/Peter Jenkinson, Directors of Corporate
Governance Time: 09.50

References:

- Enc 04 a. Covernote Scheme of Delegation.pdf
- Enc 04 b. NWL Acute Provider Collaborative Summary v1.4.pdf
- Enc 04 c. NWL Acute Provider Collaborative - SOD - v1.4 October 2022.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 3.0

This report is: Public

North West London Acute Provider Collaborative – Scheme of Delegation

Author: Dawn Clift
Job title: Programme Director, NWL Acute Provider Collaborative

Accountable director: Peter Jenkinson and David Searle
Job title: Directors of Corporate Governance

Purpose of report

Purpose: Decision or approval

The Board in Common is requested to approve the Scheme of Delegation which sets out the delegated roles and responsibilities (including delegated financial authorities) within the governance arrangements of the North West London Acute Provider Collaborative.

Report history

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

**Vice Chairs Meeting, 4
October 2022**

Executive summary and key messages

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

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

To ensure agility in decision making and to maintain oversight, the Board in common will delegate some specific responsibilities to a Board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the Board in common is not meeting. The Board in Common Cabinet will report back into the next meeting of the Board in Common on any decisions it has taken.

Financial authorities are proposed as:-

		All trusts
Capital only & cap and rev	Trust Finance Committee	As per current Trust SFIs, up to max £5m (Trust specific investment and within Trust plan)
	Collaborative Finance Committee	Between £1m - £5m (affecting 2 or more NWL acute provider trusts)
	Collaborative Board in common	>£5m
	NHSEI (via Board)	>£10m in line with latest Cabinet Office Spending Controls
Revenue only	Trust Finance Committee	As per current Trust SFIs, up to max £5m (Trust specific investment and within Trust plan)
	Collaborative Finance Committee	Between £1m - £5m (impacting on 2 or more NWL acute provider trusts)
	Collaborative Board in Common	>£5m
	NHSEI (via Board)	>£10m in line with latest Cabinet Office Spending Controls

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

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

Reason for private submission

Tick all that apply

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

If other, explain why

ESTABLISHING THE NWL ACUTE PROVIDER COLLABORATIVE

SCHEME OF RESERVED AND DELEGATED POWERS

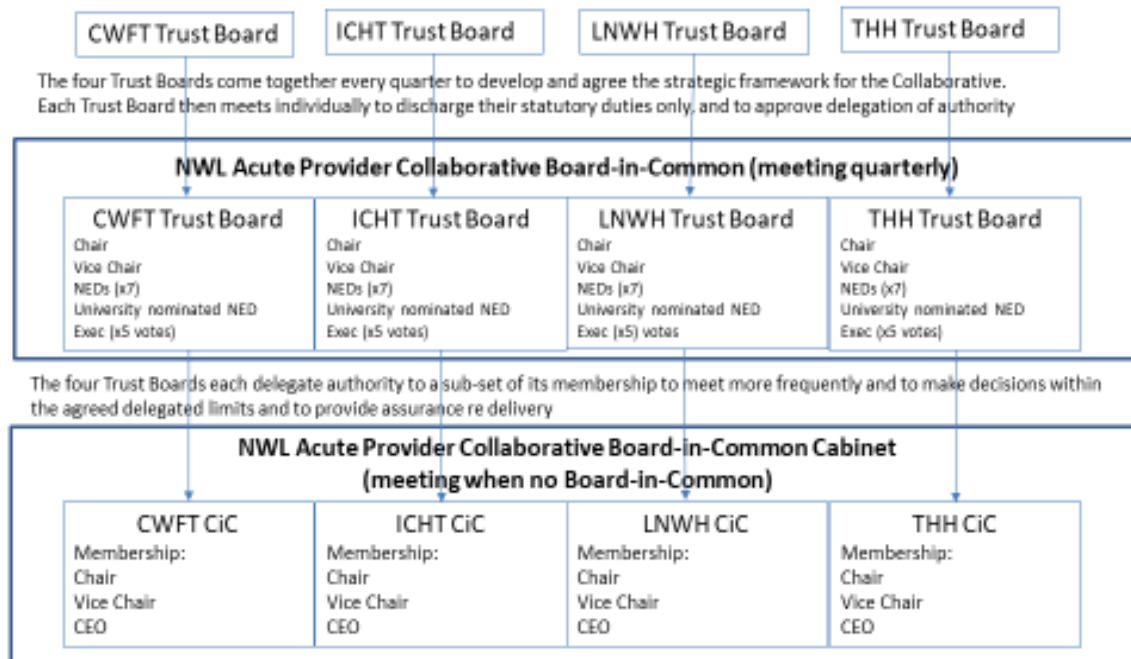
Purpose

1. The purpose of this paper is to;
 - Seek approval to the Scheme of reserved and delegated powers within the NWL Acute Provider Collaborative;
 - Seek approval to the scheme of financial delegated authority.

Background

2. On April 1, 2022 the first Chair in Common for the four acute trusts across north west London was appointed and during July 2022 the trust boards of Chelsea & Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust, (the Providers) formally agreed a governance model which establishes a Board in Common, collaborative committees and local trust board level committees, and the sharing of non-executive directors (NEDs) between trusts.
3. Each of the four acute provider trusts remains a separate statutory organisation. Although NHS Foundation Trusts are not able to set up joint committees that delegate from their full Board to a joint committee with other organisations they can, however, set up committees of their own directors. This means that while each organisation may have a committee of the Board meet in common with the other organisations, each meeting is technically separate and actions are carried out by employees of that organisation. This is the governance model which the NW London acute collaborative is using.

Board in common



Reservation and delegation of powers

- As statutory organisations, each Trust will retain its own set of Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, with each Trust Board agreeing on an annual basis what it is delegating to its committee in common so that when each Trust meets in common the matters on the agenda of the Board in common are within the delegations which have been agreed.
- Each Trust Board will also agree what authority it delegates to its own committees, to the Collaborative level committees operating on behalf of the Board in Common, and to Board in Common Cabinet. To ensure agility in decision making and to maintain oversight, the Board in common will delegate some specific responsibilities to a Board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the Board in common is not meeting. The Board in Common Cabinet will report back into the next meeting of the Board in Common on any decisions it has taken.

Scheme of reservation and delegation of powers

- The purpose of the Scheme of reserved and delegated powers for the Collaborative, attached as an appendix to this paper, is to set out the matters reserved to the Trust Boards and powers / duties delegated by the Trust Boards to the Board in Common via their respective committees in common and to the various committees in the governance model, including Trust and collaborative level committees. The scheme has been designed to comply with statutory and regulatory requirements of individual Trust Boards whilst also maximising opportunities for collaboration, openness, transparency and public accountability through the Board Committee in Common.

Trust Board

7. Each Trust will maintain an Annual General Meeting/Annual Members Meeting to discharge its statutory duties relating to the Annual Report and Accounts. As such, the Scheme of Delegation has been designed to reserve the following duties to each Trust Board of Directors (outside the remit of the Board Committee in Common):-

- Approval of annual accounts and report (annual)
- Charitable funds – annual accounts and report (annual) (where applicable)
- Receive annual management letter from external auditor (annual)
- Receive Head of Internal Audit Opinion (annual)

Board committees

8. As now, each Trust will establish a Board level committee structure, to include statutory duties (i.e audit, remuneration) and the Trust Board will delegate some powers to these committees to give time to detailed scrutiny and oversight, and to make decisions within agreed levels of authority. There may be a need for some Trusts to establish Board committees to discharge particular duties (e.g. redevelopment committees).

Board in Common

9. At the heart of the Collaborative governance model is a 'Board-in-Common' which is made up of four Committees-in-Common (CiC), with delegated authority from each of the four Trusts. Each Trust remains a statutory organisation but delegates an agreed scope of decision making to a committee of its Board. These four CiCs meet at the same time and at the same place and discuss a common agenda (the Board in Common), but decisions are taken by each individual CiCs on behalf of their Trust Board. Each CiC would owe duties to the organisation that constituted it.

10. The key features of Committees in common ("CiC"):

- each Provider remains a standalone organisation;
- each Provider delegates an agreed scope of decision making to a committee of its Board;
- each CiC would owe duties to the organisation that constituted it and would report to the Board of such organisation;
- only the members of each CiC would vote on resolutions of such CiC – there would be no delegation of powers between Providers therefore no Provider could be bound by a decision taken by another Provider's CiC. Where an individual has a common role across one or more Provider, that individual must consider the applicable Provider's best interests in relation to each matter and vote separately on each committee.
- the CiC of each Provider could have common: meeting times; meeting venues; and agendas of business (where practicable).

11. Where a power has been delegated from the Trust Board to its committee in common, decisions made at a meeting of the Board in common which are within the power of the relevant committee in common, are to be recorded as a decision of that specific committee in common, and held by the relevant Trust secretariat.

Collaborative level committees

12. Collaborative committees have been established to:-

- oversee and receive assurance that the Trust level Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

Standing Orders and Standing Financial Instructions

13. Powers specified in detail in the standing orders, reservation and delegation of powers and standing financial instructions of each Trust remain as published by each Trust;

- decisions/duties delegated by the Board to committees
- derived from the Accountable Officer Memorandum
- derived from the codes of conduct and accountability
- derived from Standing Orders
- delegations derived from Standing Financial instructions

Financial delegated authority

14. Key to the effective operating of the governance model will be the ability for appropriate and effective decision making by those groups with delegated authority, in particular in relation to financial decision-making.

15. Appendix 2 to this paper contains proposed changes to the current delegation of financial authority, developed by the four Chief Financial Officers, recognising the variation in current limits across the four trusts and the need to standardise the authority at collaborative level.

16. These financial limits are presented for approval. Once agreed, they will need to be reflected in each trust's standing financial instructions and scheme of delegated financial limits.

17. The Chair of the relevant Trust Finance Committees will consider any decision against the delegated limits to assess both whether it is within the financial limit and whether it is a matter that impacts solely on the Trust in question to determine whether the committee has delegated decision making authority.

18. The financial limits reflect latest Cabinet Office spend controls for the NHS London region.

Recommendations

19. The Board is Common is recommended to:-

- Approve the Scheme of reserved and delegated powers within the NWL Acute collaborative;
- Approve the scheme of financial delegated authority.

APPENDIX 1

Scheme of delegation – financial decisions

Current Business Case Approval Limits (September 2022):

		CWFT	ICHT	LNWH	THH
Capital only & Cap and Rev	Finance Committee	>£1m and in Trust plan		Between £1m - £5m	>£200k - £1m and in Trust plan
	Board	>£1m and not in Trust plan	>£5m <£15m	£5m-£15m	>£1m or >£200k and not in Trust plan
	NHSEI (via Board)	Significant transactions only	>£15m	>£15m	
Revenue only	Finance Committee	>£1m and in Trust plan		Between £1m - £5m	£500k - £1m
	Board	>£1m and not in Trust plan	>£5m <£15m	>£5m	>£1m
	NHSEI (via Board)	Significant transactions only	>£15m		

Proposed Business Case Approval Limits (October 2022):

		All Trusts
Capital only & cap and rev	Trust Finance Committee	As per current Trust SFIs, up to max £5m (Trust specific investment and within Trust plan)
	Collaborative Finance Committee	Between £1m - £5m (affecting 2 or more NWL acute provider Trusts)
	Collaborative Board in common	>£5m
	NHSEI (via Board)	>£10m for NHS Trusts and NHS Foundation Trusts
Revenue only	Trust Finance Committee	As per current Trust SFIs, up to max £5m (Trust specific investment and within Trust plan)

	Collaborative Finance Committee	Between £1m - £5m (impacting on 2 or more NWL acute provider Trusts)
	Collaborative Board in Common	>£5m
	NHSEI (via Board)	>£10m for NHS Trusts and NHS Foundation Trusts

NORTH WEST LONDON ACUTE PROVIDER COLLABORATIVE

SCHEME OF RESERVED AND DELEGATED POWERS

V1.4 OCTOBER 2022

Purpose

The purpose of this document is to identify those powers which will be reserved to the Trust Board and those which shall be delegated by the Trust Board to a committee-in-common to be discharged as part of the north west London acute provider collaborative Board in Common, a trust level committee or a collaborative level committee, or to the Chair or a director or an officer of the Trust.

The individual Trust Board statutorily remains ultimately accountable for all of the functions of the Trust, even those delegated by the Chair, individual directors or officers and therefore expects to receive information about the exercise of delegated functions on an annual basis, to enable it to maintain an appropriate overall monitoring role, or on an exceptional basis if required.

This scheme will be reviewed and approved by the four trust boards on an annual basis.

Scheme of Delegated Financial Authorities

The financial value of delegated authorities is described in the Scheme of Delegated Financial Authorities, aligned with, but separate from this document

Contents

The Scheme of reserved and delegated powers is in four sections:

Section 1 – Decisions reserved for the Trust Board

Section 2 – Decisions delegated to the Trust Board Committee in Common (to be discharged via the Board in Common)

Section 3 – Decisions / duties delegated to Trust level committees

Section 4 – Decisions / duties delegated to Collaborative level committees

Section 5 – Decisions delegated to Board in Common Cabinet

SECTION 1 – DECISIONS RESERVED TO THE TRUST BOARD

DECISIONS RESERVED TO THE TRUST BOARD

General Enabling Provision

The Board may determine any matter, for which it has delegated or statutory authority, in full session.

Annual Reports and Accounts

1. Receive and approve the Trust's Annual Report, Annual Governance Statement and Annual Accounts.
2. Receive and approve the Charitable funds – annual accounts and report (annual) (where applicable)
3. Receive the annual management letter from external auditor (annual)
4. Receive the Head of Internal Audit Opinion (annual)

SECTION 2 – DECISIONS DELEGATED TO THE COMMITTEE IN COMMON OF THE TRUST BOARD (BOARD IN COMMON)

The Trust board may determine that certain of its powers shall be exercised by Committee in Common of the Trust Board, that meets and operates as part of the north west London acute provider collaborative Board in Common. The terms of reference of this committee and the Board in Common shall be that determined by the Trust Board, including the reporting requirements in respect of these committees.

DECISIONS RESERVED TO THE TRUST BOARD COMMITTEE IN COMMON

General Enabling Provision

The Board may determine any matter, for which it has delegated or statutory authority, in full session.

Regulations and Control

- Ratify any urgent decisions taken by the Chair and Chief Executive Officer (CEO)
- Ratify any urgent decisions taken by the Trust Board in Common Cabinet
- Initial approval of a scheme of delegation of powers from the acute provider trust boards to collaborative committees and local Trust Committees, then two-yearly review or earlier as required.
- Require and receive the declaration of Board members' interests that may conflict with those of the board in common, and determine the extent to which that member may remain involved with the matter under consideration.
- Receive reports from committees including those that the Trust is required to produce by the Secretary of State or other regulation to establish and to take appropriate action on.
- Confirm the recommendations of the Trust's committees where the committees do not have executive powers.
- Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Trust Board Committee in Common
- Ratify use of the use of the seal, receiving an annual report of its use.
- Initial approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business, then two-yearly review by Audit, Risk and Governance Committee on behalf of the Trust Board or earlier, as required.
- Suspend or vary Standing Orders on recommendation by Audit, Risk and Governance Committee.
- Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trusts within the Collaborative and to agree modifications thereto.
- Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property across the Collaborative.
- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive Officer's attention, on recommendation by the Audit, Risk and Governance Committee.
- Discipline members of the Trust board who are in breach of statutory requirements or Standing Orders.

DECISIONS RESERVED TO THE TRUST BOARD COMMITTEE IN COMMON

Appointments/ Dismissal

- Appoint and dismiss committees that are directly accountable to the Trust Board in Common.
- Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
- Ratify proposals of the Nomination and Remuneration Committee regarding directors and senior employees.
- Appoint the Vice Chair of the Trust boards within the Collaborative
- Appoint the chief executive officers within the Collaborative.
- Ratify the appointment, and dismissal of executive directors within the Collaborative.

Strategy, Plans and Budgets

- Define the strategic aims and objectives of the Trust and the North West London acute provider collaborative.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Trusts within the Collaborative, having regard to any guidance issued by the Secretary of State.
- Approve business cases for investment with a value in excess of £5M where the business case is specific to one Trust within the Collaborative.
- Approve Business Cases for Investment over £5m, where the business case affects more than one of the Trusts within the Collaborative
- Approve Private Finance Initiative (PFI) proposals.
- Approve proposals to award contracts (other than as part of the annual NHS commissioning round) of a capital or revenue nature amounting to, or likely to amount to, over £5m.
- Approve annually Trust's business / operational plans within the Collaborative
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
- Approve the opening of bank accounts across the Collaborative.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive Officer and Chief Financial Officer (for losses and special payments) previously approved by the Boards within the Collaborative.
- Approve individual compensation payments (where permissible by Secretary of State).
- Approve proposals for action on litigation against or on behalf of the Trust within the Collaborative

Policy Determination

- Approve personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
- Approve the Trust's policies and procedures for the management of risk across the Collaborative.

Monitoring

1. Receive such reports as the Trust board sees fit from committees in respect of their exercise of powers delegated.
2. Continuous appraisal of the affairs of the Trust by means of the provision of reports as may be required from directors, committees, and officers of the Trust. All monitoring returns required by the Department of Health and Social Care (DHSC) shall be reported, at least in summary, to the Trust board.
3. Receive reports from CFO on financial performance against budget and Annual Operating Plan, and on actual and forecast income.

DECISIONS RESERVED TO THE TRUST BOARD COMMITTEE IN COMMON

Direct Operational Decisions

- The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £5 million or where there is potential for significant media interest.
- Approval of individual contracts (other than as part of the annual NHS commissioning round) of a capital or revenue nature amounting to, or likely to amount to over £5m (capital) or £5m per annum (where total exceeds £10m).

Financial and Performance Reporting Arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors and committees. All monitoring returns required by NHS England and NHS Improvement, shall be reported at least in summary, to the Trust Board.

Audit

- Ratify the appointment (and where necessary dismissal) of External Auditors within the Collaborative (by the Audit Risk and Governance Committee acting as the Audit Panel)
- Receive the annual management letter from the external auditors within the Collaborative and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Risk and Governance Committee.
- Receive the annual governance report from the Audit Risk and Governance Committees within the Collaborative including the work of Internal Audit and agree action on recommendations where appropriate

SECTION 3 – DECISIONS /DUTIES DELEGATED BY THE TRUST BOARD TO TRUST COMMITTEES

The Trust board may determine that certain of its powers shall be exercised by a Committee of the Trust Board. The composition and terms of reference of such committees shall be that determined by the Trust Board from time to time taking into account where necessary the requirements of the Secretary of State (including the need to appoint an Audit and Risk Committee and a Remuneration and Appointments Committee). The Trust board shall determine the reporting requirements in respect of these committees. Committees may not delegate such powers to sub-committees unless expressly authorised by the Trust board.

In addition to these committees of the Trust Board, the Trust Board may determine the need for additional 'local' committees. The duties and authority delegated to those committees will be documented in the respective terms of reference.

AUDIT RISK AND GOVERNANCE COMMITTEE	<p>The Committee will:</p> <ol style="list-style-type: none"> 1. Monitor the integrity of the financial statements of the Trust, including its annual report and any formal announcements relating to the Trust's financial performance and review and report to the board on significant financial reporting issues and judgements which those statements contain having regard to matters communicated to it by the auditor. 2. Review the annual report and financial statements before recommending them to the Trust board, in particular, the Committee shall review and challenge where necessary. 3. Ensure that the systems for financial reporting to the board of directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Trust board. 4. Review any other statements requiring board approval which contain financial information first, where to carry out a review prior to board approval would be practicable and consistent with any prompt reporting requirements under any law or regulation including the Listing Rules, Prospectus Rules and Disclosure Guidance and Transparency Rules sourcebook. 5. Where the Committee is not satisfied with any aspect of the proposed financial reporting by the Trust, it shall report its views to the board 6. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the Trust's goals. 7. Seek assurance that the Trust board's oversight and management of the delivery of the strategic objectives and in managing strategic, financial and operational risks, is effective, via implementation of the Board Assurance Framework. 8. Seek assurance that the monitoring of due diligence on any integration or partnership arrangement is appropriate. 9. Seek assurance on behalf of the Trust board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice 10. Utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it. 11. Ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the chief executive and board of directors. 12. Review the work and findings of the external auditor and consider the implications and management's responses to their work. 13. Review any proposal considered for commissioning work outside the annual audit plan (in its role as the Audit Panel) prior to approval.
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	<ol style="list-style-type: none"> 14. NHS trusts are required to appoint their own external auditors and directly manage the resulting contract and the relationship; trusts are required to have an auditor panel to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them. The Trust has nominated the Committee (Part I) as the Auditor Panel for the Trust. 15. The Auditor Panel will advise the Trust board on the selection and appointment of the external auditor. The Trust board must consult and take account of the Auditor Panel's advice on the selection and appointment of the Trust board on the appointment of external auditors, and publish a notice on the website within 28 days of appointing the auditor providing details of appointment, and noting auditor panel advice. 16. Request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. 17. Request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. 18. Where requested by the board, the Committee should review the content of the annual report and accounts and advise the board on whether, taken as a whole, it is fair, balanced and understandable and provides the information necessary for stakeholder to assess the Trust's performance, business model and strategy and whether it informs the board's statement in the annual report on these matters that is required under the Code. 19. Review the possible wrongdoing in financial reporting or other matters or any other matters of concern including patient care, safety, staff and bullying (including the Freedom to Speak up Guardian). 20. Review on behalf of the Trust board any proposed changes to the Standing Orders and Standing Financial Instructions. 21. Examine the circumstances of any departure from the requirements of Standing Orders and Standing Financial Instructions. 22. Monitor the Declarations of Interest & Hospitality policy with reference to the codes of conduct and accountability thereby providing assurance to the board of probity in the conduct of business. 23. Review schedules of losses and compensations annually. 24. Ensure that other board committees receive findings of other significant assurance functions as appropriate, both internal and external to the organisation, including the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors, and professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies). 25. Work and liaise as necessary with all other board committees ensuring interaction between committees and with the board is reviewed regularly, taking particular account of the impact of risk management and internal controls being delegated to different committees. 26. Review single tender waivers 27. Review schedules of debtor/creditor balances over 6 months old and over £50,000 and explanations/action plans 28. Ensure the Trust learns from national reviews by organisations such as the Care Quality Commission improvement reviews and implements all necessary recommendations to improve the safety and quality of care 29. The Committee will work and liaise as necessary with all other board committees ensuring interaction between committees and with the board is reviewed regularly, taking particular account of the impact of risk management and internal controls being delegated to different committees. 30. Maintain oversight of the effectiveness of Information Governance, including annual submission of the Information Governance Toolkit 31. Review the effectiveness of other board committees in ensuring that risk and assurance mechanisms are maintained, issues are identified and action and assurance requested on performance outside expected parameters.
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<p>REMUNERATION AND APPOINTMENTS COMMITTEE</p>	<p>The Committee will:</p> <ol style="list-style-type: none"> 1. Trust board composition <ul style="list-style-type: none"> • Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust board and make recommendations to the Trust board with regard to any changes. • Give full consideration to and make plans for succession planning for the chief executive officer and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future. • Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise. • Be responsible for identifying and nominating a candidate, for approval by the Trust board, to fill the position of chief executive officer. • Before an appointment is made evaluate the balance of skills, knowledge and experience on the Trust board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria. 2. Appointment of executive directors <ul style="list-style-type: none"> • Nominate one or more members to be actively involved with the chief executive officer in the appointment of executive director and executive team member posts, and in the design of the selection process on behalf of the Committee. • Ensure that the selection process is based on: an agreed role and person specification; the use or other involvement of any third party recruitment professionals; an interview panel to include the chief executive officer, an agreed non-executive director or directors, an external assessor representing NHS England and NHS Improvement/DHSC or successor bodies and such other persons as may be agreed to be helpful. • Ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection. This will include the Trust's inclusive recruitment standards and ensuring compliance with fit and proper person regulations (FPP). • Keep the Trust board informed of the process, procedures and timetable to which it is working, as appropriate. 3. Remuneration of executive directors <ul style="list-style-type: none"> • Agree on behalf of the Trust board the remuneration and terms of service of the executive directors and that the executive directors are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant. Approve the remuneration policy for executive directors and executive team members, including approving the performance criteria for bonuses where appropriate and agreed. For the Chief executive, the Committee will advise the Chair regarding the framework for bonuses, in accordance with contract of employment. • Agree and review annually the remuneration policy framework for very senior managers (VSM) not on national contracts, including executive directors. Determination of the salaries of very senior managers, other than executive directors, is delegated to the chief executive officer or relevant executive director, advised by the director of people & OD and working within the agreed policy framework. The committee will review annually the earnings of such managers including senior clinicians and clinical managers. • Establish the parameters for the remuneration and terms of service for the appointment of executive directors, with delegated authority of the chief executive officer to agree starting salaries within the agreed parameters.
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	<ul style="list-style-type: none"> • Agree the termination of contract of executive directors and the payment of any redundancy or severance packages in line with prevailing national guidance. <p>4. Performance and Succession Planning</p> <ul style="list-style-type: none"> • Receive assurance that appropriate annual appraisals have been completed by the Chief executive for executive directors and that development plans are agreed with individuals. • Ensure the capability of potential or nominated deputies for executive directors to effectively deputise during periods of extended absence on the part of the Executive directors. • oversee an assessment of the capability and succession potential of the Trust leaders in order to identify any strategic gaps requiring appropriate intervention and to receive assurance regarding the succession plans for directors and talent management; including assurance regarding equality in the succession planning
<p>FINANCE AND PERFORMANCE COMMITTEE</p>	<p>The Committee will:</p> <ol style="list-style-type: none"> 1. Advise the Trust board on financial policies; 2. Recommend to the Trust board, the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust board; 3. Review the Business Plan including the annual revenue and capital budget prior to submission to the Trust board for approval; 4. Review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust board; 5. Review compliance with the self-assessment quality checklist for the annual national cost collection or other equivalent submission; 6. Review, at the request of the Trust board, specific aspects of financial performance where the Trust board requires additional scrutiny and assurance; 7. Review the Trust's projected and actual cash and working capital; 8. Approve and keep under review, on behalf of the Trust board, the Trust's investment and borrowing strategies and policies; 9. Ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control); 10. Review the financial risks; 11. Establish the overall methodology, processes and controls which govern the Trust's investments; 12. Evaluate, scrutinise and monitor costs and funding relating to investments (such as Redevelopment and any major pandemic or other incident requiring additional scrutiny of costs)), including regular review of the capital programme ensuring value for money; 13. Review, and recommend to Trust board, the Trust's treasury management and working capital and estates strategies; 14. Review and recommend to Trust board, the Trust's estates strategies and ensure the associated funding arrangements are in place. 15. Review post project evaluations for capital and revenue projects (above £5million) approximately 12 months after go live of project to review whether anticipated outcomes/savings had been achieved; 16. Evaluate and scrutinise the financial and commercial validity of individual investment decisions over £5m recommended for approval by the executive management board, including the review of outline and final business cases, and service development tenders and procurement contracts, for onward recommendation for approval by the Trust board. The current delegated limit for the Trust is £15 million; 17. Approve all business cases up to a maximum value of £5M where the business case is specific to the Trust and is within the Trust plan;

	<ol style="list-style-type: none"> 18. Review and make recommendations to the Collaborative Finance and Performance Committee on all business cases with a value above £5M where the business case affects at least 2 acute Trusts within the Collaborative 19. Consider quality implications for all financial cases and escalate to the Quality Committee as appropriate. 20. Review operational planning and performance for the Trust, including activity, capacity and winter planning, identifying the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning; 21. Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning; 22. Review the Transformation programme and receive progress reports on key projects within that programme. 23. Refer other matters to other Committees as appropriate. 24. To receive updates and understand emerging system level risks and the strategic and financial impacts on the Trust and consider how collaboration with the ICS can help in managing ICHT specific financial risks
<p>PEOPLE COMMITTEE</p>	<p>The Committee will:</p> <ol style="list-style-type: none"> 1. Review the development and delivery of the Trust's sustainable workforce strategy. 2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies. 3. Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities. 4. Oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback. 5. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board. This includes raising concerns and freedom to speak up reports to the People Committee and Board. 6. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area. 7. Oversee the development and delivery of a strategy regarding a sustainable workforce (more generally). That would include development of new roles, recruitment and retention etc. The safe staffing report would be an example of a source of assurance. 8. Assess the workforce strategies and plans to support transformational change, service redesign and pathways of care that make best use of new technologies, the use of apprenticeships, introduction of new roles and innovative working across traditional professional and organisational boundaries. 9. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management. 10. Review the Trust's strategy and performance as a provider and enabler of health and care education. 11. Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system, including risk training. 12. Review the Trust's strategic contribution to the development of the health and care workforce. 13. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff. 14. Oversee the development and delivery of a Trust Staff Health and Well-being Strategy 15. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

	<ol style="list-style-type: none"> 16. Establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee. 17. Review progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions. 18. Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these. 19. Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board in relation to the Committee's purpose and function. 20. Ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit & Risk, Quality & Safety and Finance & Performance Committees. 21. Review and shape the quality-related content of periodic workforce reports to the Board.
<p style="text-align: center;">QUALITY COMMITTEE</p>	<p>The Committee will:</p> <ol style="list-style-type: none"> 1. Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents and taking action to reduce risks and improve clinical quality; 2. Receive and review a thematic summary of the lessons learned from serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning; 3. Receive and review quality implications of business cases, as appropriate. 4. Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults; 5. Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act; 6. The Committee will review the quality-related risks and will identify emerging quality risks. 7. Receive assurance that all cost improvement programmes (CIPs) have been quality impact assessed and measures taken to mitigate risk and protect quality of care. 8. Establish and oversee the Quality Strategy and priorities underpinned by the Trust's strategic goals. 9. Approve and assure delivery of the annual programme of Trust-wide clinical audits. 10. Obtain assurance that NICE Guidelines and Technology Appraisals are implemented. 11. Obtain assurance that all requirements as set by NHS Resolution regarding CNST are achieved. 12. Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations. 13. Oversee the Trust's work to meet the Care Quality Commission's (CQC) quality standards. 14. Work with partners to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care. 15. Determine whether the Trust is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. 16. Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services, and developed in line with national, regional and commissioning requirements. 17. Nurture a quality improvement culture across the Trust and celebrate achievement in quality improvement. 18. Obtain assurance that the divisional quality groups are effectively coordinating quality and clinical governance activity within the Trust.

	<ol style="list-style-type: none"> 19. Ensure that board assurance framework reflects the assurances for which the Committee has oversight, and that risks highlighted are appropriately reflected on the risk registers. 20. Approve and assure delivery of the Trust's patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are a key element of the work of quality and clinical governance teams across the Trust. 21. Receive and review a thematic summary of patient experience and feedback including Friends and Family Test, formal complaints and Patient & Advice and Liaison concerns. 22. To be assured that lessons are learned and that actions/improvements are implemented to ensure that patients' experience of care is improved. 23. Obtain assurance that patient access targets are being delivered. 24. Obtain assurance that effective channels are in operation for communicating and managing issues of clinical governance to relevant managers, staff and external stakeholders. 25. Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented. 26. Review the aggregated analysis of adverse events, complaints, claims and litigation to identify common themes or trends to take forward as improvement projects, as sponsored by the Committee
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SECTION 4 – DECISIONS /DUTIES DELEGATED BY THE TRUST BOARDS TO COLLABORATIVE COMMITTEES

As part of the governance model for the north west London acute provider collaborative, the trust boards of the four acute provider trusts have agreed to establish some collaborative level committees. The purpose of these committees is to support the Board in Common (the four Trust committees in common) exercise their powers by taking a collaborative view of risk and assurance, identifying and addressing key themes across the four trusts.

The composition and terms of reference of such committees shall be that determined by the Board in Common from time to time, taking into account where necessary the requirements of the Secretary of State. The Board in Common shall determine the reporting requirements in respect of these committees. Collaborative committees may not delegate such powers to sub-committees unless expressly authorised by the Board in Common.

<p>FINANCE AND PERFORMANCE COMMITTEE</p>	<p>The Committee will:</p> <ul style="list-style-type: none"> • Advise and recommend to the Board in Common on collaborative financial and commercial policies; • Recommend to the Board in Common, the Collaborative medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used. • Review the proposed annual business plans proposed by Trusts, including the annual revenue and capital budgets, to provide a collaborative view • Review the trusts' financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Board in Common; • Review trusts' compliance with the self-assessment quality checklist for the annual national cost collection or other equivalent submission, and agree collaborative level recommendations; • Review the financial risks escalated by trust committees and agree mitigations at collaborative level; • Consider costs and funding relating to investments at collaborative level; • Approve all business cases with a value between £1M and £5M where the business case impacts on more than one of the acute providers in the collaborative, taking advice from the Infrastructure Collaborative Committee where that business case applies to estate and digital infrastructure; • Review and make recommendations to the Board in Common, taking advice from the Infrastructure Collaborative Committee where that business case applies to estate and digital infrastructure, on all business cases with a value in excess of £5M • Review operational planning and performance across the collaborative, including activity, capacity and winter planning, identifying the key issues and risks requiring discussion or decision by the Board in Common; • Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Board in Common; • Refer other matters to other Committees as appropriate. • To receive updates and understand emerging system level risks and the strategic and financial impacts on the Collaborative, and consider how collaboration with the ICS can help in managing collaborative level financial risks.
<p>PEOPLE COMMITTEE</p>	<p>The Committee will:</p> <ul style="list-style-type: none"> • Ensure the development and delivery of the Collaborative People Strategy and priorities. • Seek assurance that the trusts' People Strategy and policies effectively respond to national and regional people strategies and policies.

	<ul style="list-style-type: none"> • Review strategic intelligence and research evidence on people and work, and distil their relevance to the people related strategic priorities. • Oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback. • Oversee the development and delivery of the Trusts’ strategies and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area. • Oversee the development and delivery of strategies regarding a sustainable workforce, including development of new roles, recruitment and retention. • Review plans for ensuring the development of leadership and management capability, including the Collaborative approach to succession planning and talent management. • Review the Collaborative strategy and performance as a provider and enabler of health and care education. • Review the accessibility and impact of health and well-being strategies and improvement programmes across the Collaborative, in particular, for staff with protected characteristics. • Review progress against workforce performance metrics and seek assurance around any performance issues identified, including proposed corrective actions. • Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these. • Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee.
<p style="text-align: center;">QUALITY COMMITTEE</p>	<p>The Committee will:</p> <ul style="list-style-type: none"> • Establish and oversee the delivery of Collaborative quality strategy and priorities, informed by the trusts’ quality priorities, including: <ul style="list-style-type: none"> ○ Deteriorating patients/treatment escalation; ○ Gaining insight from the CRGs & GIRFT; ○ National patient safety strategy; ○ Maternity; ○ Mortality & clinical harm review • Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services in the Collaborative, and developed in line with national, regional and commissioning requirements. • Obtain assurance that trusts has effective mechanisms for managing clinical risk, including improving service user safety, learning from incidents and taking action to reduce risks and improve clinical quality; • Develop Collaborative level patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are a key element of the work of quality and clinical governance teams across trusts. • Ensure that lessons are learned across the Collaborative from serious adverse incidents, including ‘never’ events, coroners’ post-mortem reports, medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning across the Collaborative; • Review quality related performance metrics across the Collaborative and agree collaborative level actions where appropriate • Obtain assurance that trusts have the assurance mechanisms in place to ensure compliance with statutory and mandatory quality related requirements, including:

	<ul style="list-style-type: none"> ○ Safeguarding children and young people and vulnerable adults; ○ Compliance with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act; ○ NHS Resolution requirements regarding CNST; ○ CQC fundamental standards of care; ○ Infection control ○ Learning from deaths ● Consider Collaborative level quality-related risks and identify emerging quality risks; ● Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations. ● Nurture a quality improvement culture across the Collaborative and celebrate achievement in quality improvement.
<p>INFRASTRUCTURE AND CAPITAL COMMITTEE</p>	<p>The Committee will</p> <ul style="list-style-type: none"> ● Provide assurance on the development and implementation of estate and digital infrastructure strategies across the Collaborative within defined and prioritised capital funding resources. ● Oversee and receive assurance that the Trust level processes governing Estates and Digital are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response ● Oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term estate and digital infrastructure improvements ● Prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements in the management of estate and digital infrastructure ● Provide assurance on the development and implementation of the Information and IT Strategy at Collaborative level ● Provide assurance on the development and implementation of the Sustainability Strategy at Collaborative level ● Provide assurance on the development and implementation of the Estate Strategy at Collaborative level ● Provide advice to the Finance and Performance Collaborative Committee on any estate or digital infrastructure business cases that come to that committee. ● Draw to the Board in Common's attention matters they need to agree or note.

SECTION 5 – DECISIONS /DUTIES DELEGATED BY THE TRUST BOARDS TO THE BOARD IN COMMON CABINET

To ensure agility in decision making and to maintain oversight, the board in common will delegate some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the board in common is not meeting. The Board in Common Cabinet will report on any action it has taken to the next meeting of the Board in Common.

Delegated responsibilities include:-

- Discussing operational planning and performance across the collaborative, including activity, capacity, finance, quality and workforce related issues, identifying the key issues and risks;

- Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Board in Common;
- Refer other matters to other Committees as appropriate.

3.1 Terms of Reference:

Decision Item Speaker: David Searle/Peter Jenkinson, Directors of Corporate
Governance Time: 10.00

- Board in Common
- Collaborative Quality Committee
- Collaborative Finance and Performance Committee
- Collaborative People Committee
- Collaborative Infrastructure and Capital Committee
- Collaborative Nomination and Remuneration Committee

References:

- Enc 05 (1) NWL Collab Covernote Report Terms of Reference.pdf
- Enc 05 a. Board in Common ToR v1.2 29.9.22.pdf
- Enc 05 b. NWL Collaborative Quality Committee ToR 1.4 23.08.22 - Final.pdf
- Enc 05 c. NWL Collaborative Finance and Performance Committee ToR v1.2 22.8.22.pdf
- Enc 05 d. NWL Collaborative People Committee v1.5 28.9.22.pdf
- Enc 05 e. NWL Collaborative Infrastructure and Capital Committee ToR v1.4 22.8.22.pdf
- Enc 05 f. NWL Nomination and Remuneration Committee Terms of Reference.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 3.1

This report is: Public

North West London Acute Provider Collaborative – Terms of Reference

Author: Dawn Clift
Job title: Programme Director, NWL Acute Provider Collaborative

Accountable director: Peter Jenkinson and David Searle
Job title: Directors of Corporate Governance

Purpose of report

Purpose: Decision or approval

The Board in Common is requested to approve the Terms of Reference which set out the governance arrangements for the North West London Acute Provider Collaborative.

Report history

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

Collaborative Committees 01/09/2022 Recommended for approval		
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Executive summary and key messages

In accordance with the governance framework approved by the 4 Trust Boards which form the NWL Acute Provider Collaborative in July 2022, Terms of Reference have been developed for:-

The Board in Common

The Collaborative Finance and Performance Committee

The Collaborative Quality Committee

The Collaborative People Committee

The Collaborative Infrastructure and Capital Committee

Each of the above Collaborative Committees met for their inaugural meeting in September 2022 and are recommending approval to the Board in Common for their respective terms of reference.

Approval is also required to the Terms of Reference of the Board in Common and the Collaborative Nomination and Remuneration Committee.

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

Positive impact on all of the above domains. The two Councils of Governors within the Collaborative have formally received the governance framework without objection. The governance framework does not impact on the statutory responsibilities of Governors or individual Trust Boards.

Reason for private submission

Tick all that apply

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

If other, explain why

**North West London Acute Provider Collaborative
Board in Common
Terms of Reference**

1. Scope

- a. The North West London Acute Provider Collaborative ('the Collaborative') is the collective governance vehicle for joint decision making, with delegated authority for the four NHS acute provider Trusts in North West London.
- b. The Collaborative is one part of the wider North West London Integrated Care System which is committed to putting combined efforts into tackling health inequalities across its resident populations including access, experience and outcomes.
- c. The Board in Common for the Collaborative is made up of the members of the 4 NHS acute provider Trust Boards of Directors (The Hillingdon Hospitals NHS Foundation Trust, Chelsea and Westminster Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust). It is overall responsible for leading and governing the strategic aims and objectives of the Collaborative to assure delivery of more equitable health outcomes across North West London.

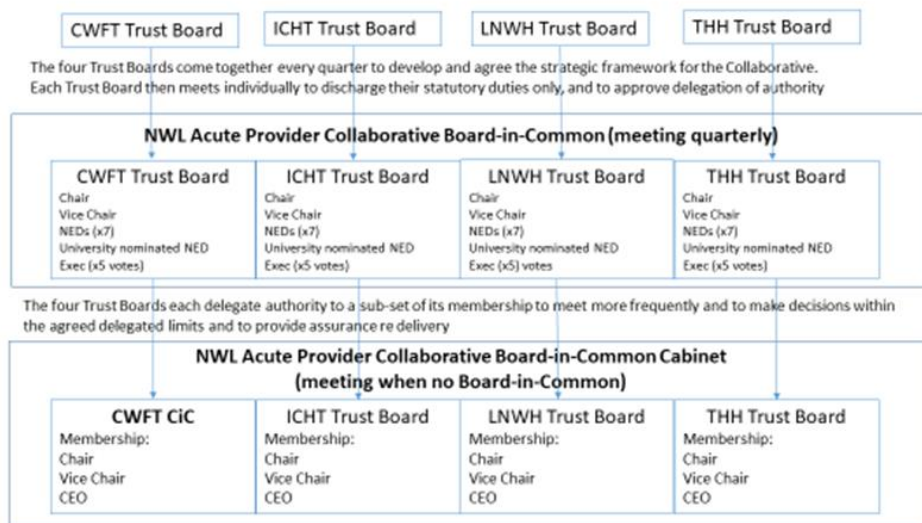
2. General Responsibilities of the Board in Common

- a. Ensuring there is a clear vision and strategy for the Collaborative that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed.
- b. Ensuring alignment of all Trusts to the North West London Acute Provider Collaborative statement of intent and objectives
- c. Providing overall strategic oversight and direction to the improvement of services within the Collaborative
- d. Implementing effective governance structures and clear lines of reporting and accountability across the Collaborative
- e. Implementing a scheme of delegation of powers from the Acute Provider Trust Boards to Collaborative Committees
- f. Assuring the collective and individual performance of the Trusts with regard to their statutory obligations, regulatory requirements, national targets and local priorities (including access to services, quality of care, financial efficiency and workforce wellbeing and development).
- g. Ensuring relationships are maintained with stakeholders, regulators, the public, governors, staff and patients in a way that is wholly consistent with public sector values and probity
- h. To emphasize the primacy of individual Trusts' relationship with their local place, but also to set the expectation that:
 - i. Where agreed through the BiC there will be service delivery, development work and clinical/operational relationships that require a 'NWL first' viewpoint, rather than an individual Trust viewpoint.

- ii. All Trusts within the collaborative take informed decisions in consultation with other collaborative partners and relevant stakeholders where there might be an impact on others' services.
 - iii. The BiC will consider and agree adoption of joint policies and procedures across all organizations that will benefit the work of the collaborative.
- i. Formally recommending the roles and responsibilities within identified workstreams, reviewing the key deliverables and ensuring adherence with required timescales;
 - j. Receiving assurance from Collaborative Committees that report to the Board in Common that identified workstreams have been subject to robust engagement and impact assessments;
 - k. Reviewing and identifying the risks associated with the performance of any of the Trusts in terms of their local obligations and impact to the Collaborative, assuring themselves of remedial and mitigating actions where appropriate;
 - l. Receiving assurance that the risks associated with the Collaborative and local work programme are being identified, managed and mitigated;
 - m. Formulating, agreeing and assuring strategies for delivery of the Collaborative workplan;
 - n. Receiving escalation reports from the Collaborative Committees on the delivery of strategic aims and objectives, highlighting the benefits of scale and common/consistent approaches on relevant issues, successes and opportunities for shared learning and identifying risks, associated impact and residual actions
 - o. Shaping a positive culture for the Acute Provider Collaborative
 - p. Approving outline and final business cases for investment over £5M where the business case affects more than one of the acute Trusts within the Collaborative

3 . Members of the Board in Common and its Cabinet

Board-in-Common



Board in Common

- a. All Non-executive Directors and the five identified Executive Directors of each of the four acute NHS Trusts will be voting members of the Board in Common. Due to legislative restrictions, the two non NHS Foundation Trusts will each have 2 Non-executive Directors acting in a designate capacity. Those in a designate capacity do not carry voting rights at the Board in Common.

Cabinet of the Board in Common

- b. Each Trust will appoint their Chair, Chief Executive and Vice Chairs to a seat on the Cabinet of the Board in Common. The Cabinet of the Board in Common will have delegated decision making authority from the Board in Common on behalf of the 4 acute provider Trusts.
- c. Deputies will be permitted to attend the Cabinet on the behalf of a Member. The deputy must be a voting board member of the Board in Common for the respective Trust and will be entitled to attend and be counted in the quorum at which the Member is not personally present.
- d. Each Trust will be considered as one entity within the Collaborative.

4. Proceedings of the Board in Common

- a. The Board in Common will meet at least four times a year in public. In addition an annual strategic meeting will be held to review overall progress and set the direction and objectives for the year ahead. During intervening periods, the Board in Common will partake in Board Development Sessions to further progress the culture, efficacy and strategic direction of the Collaborative.
- b. The Chair may call additional meetings as required. Other members may request the chair to call additional meetings by making individual representation, although the Chair will make the final decision on whether to proceed.
- c. The Board in Common shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the Members. It is agreed by the Trusts that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Trusts each acting within existing accountability arrangements of the Trusts' respective organisations and the reporting arrangements of the Board in Common into the individual provider Board meetings as and when these take place.
- d. The Chair in Common will Chair the Board in Common. The Chair will attempt to ensure they are able to attend every meeting over that period. In cases of urgent, unavoidable absence the Chair cannot attend, one of the vice Chairs of the 4 acute provider Trusts will be asked to step in.
- e. The Board in Common may regulate its proceedings as they see fit as set out in these Terms of Reference.
- f. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Trust has at least four members present of which at least 2 must be in a Non-executive Director capacity. Designate Non-executive Directors do not count towards quoracy at the Board in Common.
- g. Members of all Trusts will be required to declare any new conflicts of interest or any relevant conflicts of interest at the beginning of each meeting.
- h. A meeting of the Board in Common may consist of a conference between the Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

i. Each Member will have an equal say in discussions and will look to agree recommendations in line with the principles of the Collaborative.

j. Any issues to be raised within individual acute provider Trusts or through the Collaborative Committee governance structure will be noted and listed for action, with a dedicated agenda item reserved for this purpose.

k. The Board in Common will review the meeting effectiveness at the end of each meeting with a dedicated agenda item reserved for this purpose.

5. Decision making within the Collaborative

a. Each Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their Trust's Scheme of Delegation.

b. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Trusts, Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the service area in accordance with the Key Principles and ambitions of the Collaborative when making decisions at Board in Common meetings.

c. In respect of matters which require decisions where all Trusts are affected, the Trusts will seek to make such decisions on the basis of all Members reaching an agreed consensus decision in common in accordance with the Key Principles.

6. Attendance of third Parties at the Board in Common

a. The Board in Common shall be entitled to invite any person to attend, such as advisors, experts by experience or Partnership/System leaders. The Chair will agree final attendance lists for each meeting.

7. Administration for the Board in Common

a. Meeting administration for the Board in Common will be provided by the Corporate Governance Teams from within the Collaborative. This includes maintaining the register of interests and the minutes of the meetings. Members are required to openly and proactively declare and manage any conflicts of interests.

b. The Chair will be responsible for finalising agendas and minutes, based on the agreed workplan and in collaboration with the Collaborative corporate governance advisors.

c. Where required by the agenda, governance leads from the Collaborative will be asked to attend and provide advice to the Board in Common on decision making and due diligence.

d. Papers for each meeting will be sent by the Corporate Governance Teams to Members no later than five working days prior to each meeting. By exception; and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

e. The agenda and minutes of the Board in Common will be shared with the 2 Councils of Governors representing the 2 NHS Foundation Trusts within the Collaborative.

f. Any items not for public consumption will be marked as private in the minutes and be noted at the closed Meeting of the Collaborative Board in Common but not circulated with the public papers.

8. Review

a. The Board in Common will review these Terms of Reference at least annually.

**North West London Acute Provider Collaborative
Collaborative Quality Committee
Terms of Reference**

1. Overarching Purpose

1.1 To support the discharge of each Board's respective duties and powers and their combined responsibilities by securing continuous improvement in the quality of services and outcomes in relation to the safety of services, effectiveness of services and the quality of the experience received by patients.

1.2 The overarching role of the Collaborative Quality Committee in Common is three fold:

- To oversee and receive assurance that the Trust level Quality Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed 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

1.3 The Collaborative Quality Committee is responsible for to oversee and receive assurance regarding to:-

- Management of risks identified by the Trust Quality Committees.
- Identification and management of shared risks that would benefit from a collaborative-wide approach.
- Development and application of quality metrics that facilitate the removal of unwarranted variation, levelling up of quality across the collaborative and indicate the existence or emergence of quality issues anywhere within the collaborative.
- Driving the collaborative towards evidence based best practice through collaborative-wide projects and the application of data and models of care from GIRFT, Model Hospital, Rightcare and other reliable sources.
- Oversight and assurance on the development of joint models of care that optimise the patient pathway across the collaborative
- Oversight and assurance on the development of improved patient and community engagement across the collaborative

2. Specific Duties and Responsibilities

- To oversee and provide assurance that the Trust level Quality Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - Review the Integrated Quality Dashboard for the Collaborative and query any variation in provider outcomes to seek assurance or to give advice on remedial actions that can be taken to improve performance. Escalate any risks/concerns and successes to the Board in Common as appropriate.

- Receive regular updates on collaborative performance against National Patient Safety Improvement Programmes and, where appropriate, provide advice on how issues identified should be addressed.
- Receive updates/assurance reports from each local provider Quality Committee on issues identified through the Patient Safety Incident Response Framework and seek assurance on how serious patient safety incidents are being addressed through this framework.
- Review major patient safety incidents from local provider Quality Committees to identify any similarities, trends or areas for focussed and/or collaborative wide learning.
- Review national inquiries for major safety concerns in the NHS to ensure learning is adopted and adhered to across the Collaborative including the Ockenden report.
- Promote within the Collaborative a just culture of open and honest reporting of any situation that may threaten the quality of patient care
- Review the relevant quality related risks within the Board Assurance Framework/Strategic Risk Register and report into the Board in Common on levels of assurance of mitigation
- To oversee and assure collaborative-wide interventions for short and medium term improvements
 - Nurture a quality improvement culture across the Collaborative by overseeing existing quality improvement programmes and expanding the use of effective quality improvement programmes more widely.
 - Oversee the approach to ‘lessons learnt’ across the Collaborative so that best practice can be shared and implemented
 - Consider themes and trends emerging from patient feedback across the Collaborative and oversee any actions to address any concerns that require a collaborative response/steer.
 - Consider themes and trends emerging from clinical audit, R&I and quality standards such as GIRFT across the Collaborative and oversee any actions to address any concerns that require a collaborative response/steer.
 - Ensure that the quality of care provided to patients is improving and developing to eradicate health inequalities across North West London.
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
 - Review and monitor the implementation of the Patient Safety Strategy across the Collaborative and advise on areas of priority.
 - Ensure that strategies supporting Quality (Patient Safety, Clinical Effectiveness and Patient Experience) are continually meeting the needs of patients accessing services and determine whether the Collaborative is improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan.

3. Composition

Membership

3.1 The members of the Committee are appointed by the Boards and will be made up of:

- A Vice Chair from the Board in Common as the Collaborative Committee Chair
- Non-executive Director Chairs of the 4 Acute Provider Trust Quality Committees

- Lead CEO for Quality for the Collaborative

3.2 The lead CEO's Trust will provide secretariat and governance support to the Committee.

4. Meeting arrangements

Attendance

4.1 Members of the Committee are expected to attend meetings wherever possible. In exceptional circumstances and subject to prior approval from the Chair of the Committee, a deputy can attend.

4.2 Chief Medical Officers and Chief Nursing Officers from each of the 4 acute provider Trusts have a standing invitation to attend all meetings of the Collaborative Quality Committee.

4.3 The Collaborative Chair in Common may attend any meeting of the Committee (see para 3.6 re quoracy). At the invitation of the Committee Chair, other executive directors, senior managers or non-executive directors may also attend the Committee meetings.

4.4 The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Meetings

4.5 The Collaborative Committee will meet (including by telephone or video conferencing) at least four times a year, or more frequently as determined by the Committee Chair. Any member of the Committee can ask the Committee Chair for a meeting to be convened in person, by video conference or by telephone, or for a matter to be considered in correspondence/e governance.

4.6 The quorum for meetings is 3 members, including

- At least 2 Non-executive Directors, one of which will Chair the meeting
- Lead CEO for Quality for the Collaborative or Executive deputy agreed by the Chair

4.7 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed shall be circulated to each member of the Committee and any other person required to attend, no later than four working days before the date of the meeting. Supporting papers (including a rolling 12-month forward plan) shall be sent to Committee members, and to other attendees as appropriate, no later than four working days before the date of the meeting.

4.8 The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

4.9 Draft minutes shall be sent to the Committee Chair within 1 week of the meeting and submitted for formal agreement at the next meeting.

5. Declarations of Interest

5.1 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests where there is a conflict with an agenda item or matter under discussion, at the start of the meeting, or where there is a change to their published declaration of interests. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion or otherwise limit their involvement in the meeting.

6. Reporting Responsibilities

6.1 The Committee's Chair shall report formally to the Board in Common on its proceedings after each meeting.

6.2 The Committee will make whatever recommendations to the Board it deems appropriate in any area within its remit where action or improvement is needed.

6.3 The Committee will receive escalation reports from each of the 4 acute provider Quality Committees

7. Other Matters

The Committee will:

7.1 have access to sufficient resources to carry out its duties

7.2 consider any other matters where requested to do so by the Board in Common and the 4 acute Provider Quality Committees within the NWL Acute Provider Collaborative

7.3 review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

8. Authority

The Committee is authorised:

8.1 to seek any information it requires, or request attendance at a meeting, from any employee or any other person in order to perform its duties

8.2 to obtain legal or other professional advice on any matter within its terms of reference, subject to Board in Common approval.

**North West London Acute Provider Collaborative
Finance and Performance Collaborative Committee
Terms of Reference**

1. Overarching Purpose

- 1.1 The Finance and Performance Collaborative Committee is a non-statutory standing sub-committee of the North West London Acute Provider Collaborative Board in Common and is established to provide advice and assurance to the Board in Common (BiC) on the effectiveness of the financial strategy and planning, on the operational performance of the Collaborative and on the commercial strategy, in-year capital investments and development of the Collaborative operational infrastructure.
- 1.2 The overarching role of the Collaborative Finance and Performance Committee in Common is three fold:
- To oversee and receive assurance that the Trust level Finance and Performance Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
 - To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
- 1.3 The Finance and Performance Collaborative Committee is responsible for:
- Considering, advising and governing the Collaborative's medium-term financial strategy, in relation to both revenue and capital
 - Providing the BiC with assurance/oversight of the in year financial performance of the Collaborative
 - Gaining assurance on the effective operational performance of the Collaborative, with a focus the constitutional standards
 - Effective and efficient use of resources and assets.
 - Ensuring that the Collaborative is meeting statutory and regulatory reporting standards and requirements; including constitutional standards.

2. Specific Duties and Responsibilities

- 2.1 The Finance and Performance Collaborative Committee shall oversee and provide assurance to the BiC on the following areas:
- To oversee and provide assurance that the Finance and Performance Trust level committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response including;
 - Gaining assurance on the effective operational performance of the Collaborative, with a focus the constitutional standards
 - Recovery of elective care, emergency care and diagnostic capacity, not just to pre-pandemic levels but to deliver sustainable reductions in waiting and treatment times that are significantly better than before the pandemic;
 - Reviewing the Integrated Performance Dashboard for the Collaborative and querying any variation in provider outcomes to seek assurance or to give advice on remedial

- actions that can be taken to improve performance. Escalate any risks/concerns and successes to the Board in Common as appropriate.
 - Providing the BiC with assurance/oversight of the in-year financial performance of the Collaborative
 - Reviewing the financial performance of the Collaborative and querying any variation in provider outcomes to seek assurance or to give advice on remedial actions that can be taken to improve performance. Escalate any risks/concerns and successes to the Board in Common as appropriate.
 - Monitoring the effectiveness of the Collaborative's financial and operational performance reporting systems, and KPIs
 - Ensuring the effective and efficient use of resources and assets.
 - Ensuring that the Collaborative is meeting statutory and regulatory reporting standards and requirements; including constitutional standards.
- To oversee and assure collaborative-wide interventions for short and medium term improvements
 - Considering, advising and governing the Collaborative's medium-term financial strategy, in relation to both revenue and capital
 - supporting the Collaborative's mission to address the health inequalities that exist in our population and eliminate inequity in access to our services;
 - Reviewing financial planning, assumptions and forecasting in relation to budgets, balance sheet, capital, savings and transformation improvement plans across the Collaborative, ensuring these are efficiently and effectively managed.
 - Providing advice and support on significant financial and commercial policies prior to recommendation at the Board for approval (where required). This includes policies related to costings, revenue, capital, working capital, treasury management, investments and benefits realisation.
 - Standardising operational management around identified best practice
 - Optimising back-office functions to improve quality and value for money
 - Standardising recording processes to create accurate and comparable data sets
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
 - Seeking opportunities to improve quality and value for money by integrated service delivery
 - Reviewing relevant areas of the Board Assurance Framework gaining assurance around controls, mitigation and action plans in place to address significant risks.

3. Composition

Membership

3.1 The members of the Committee are appointed by the Boards and will be made up of:

- A Vice Chair of the Board in Common as the Collaborative Committee Chair
- Non-executive Director Chairs of Local Provider Finance and Performance Committees
- Lead CEO for Finance and Performance for the Collaborative

3.2 The lead CEO's Trust will provide secretariat and governance support to the Committee.

4. Meeting arrangements

Attendance

4.1 Members of the Committee are expected to attend meetings wherever possible. In exceptional circumstances and subject to prior approval from the Chair of the Committee, a deputy can attend.

4.2 Chief Financial Officers and Chief Operating Officers from each of the 4 acute provider Trusts are invited to attend any meeting of the Collaborative Committee.

4.3 The Collaborative Chair in Common is entitled to attend any meeting of the Committee. At the invitation of the Committee Chair, others may also attend the Committee meetings.

4.4 The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Meetings

4.5 The Collaborative Committee will meet (including by telephone or video conferencing) at least four times a year, or as determined by the Committee Chair. Any member of the Committee can ask for a meeting to be convened in person, by video conference or by telephone, or for a matter to be considered in correspondence/e governance.

4.6 The quorum for meetings is 3 members, including

- At least 2 Non-executive Directors
- Lead CEO for Finance and Performance from the Collaborative

4.7 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed shall be circulated to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members, and to other attendees as appropriate, no later than five working days before the date of the meeting.

4.8 The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

4.9 Draft minutes shall be sent to the Committee Chair within four business days of the meeting and submitted for formal agreement at the next meeting.

5. Declarations of Interest

5.1 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting.

6. Reporting Responsibilities

6.1 The Committee's Chair shall report formally to the Board in Common on its proceedings after each meeting.

6.2 The Committee will make whatever recommendations to the Board it deems appropriate in any area within its remit where action or improvement is needed.

6.3 The Committee will receive escalation reports from each of the local provider Finance and Performance Committees

7. Other Matters

The Committee will:

7.1 have access to sufficient resources to carry out its duties,

7.2 consider any other matters where requested to do so by the Board in Common and Local Provider Finance and Performance Committees within the NWL Acute Provider Collaborative

7.3 review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

8. Authority

The Committee is authorised:

8.1 to seek any information it requires, or request attendance at a meeting, from any employee or any other person in order to perform its duties;

8.2 to obtain, legal or other professional advice on any matter within its terms of reference, subject to Board in Common approval.

**North West London Acute Provider Collaborative
Collaborative People Committee
Terms of Reference**

1. Overarching Purpose

1.1 The North West London Acute Provider Collaborative has established a Collaborative People Committee (the Committee) as a non-statutory committee of the Board in Common to support the exercise of the respective duties and powers of the Boards of the 4 acute provider Trusts and their respective People Committees in their responsibilities.

1.2 The overarching role of the Collaborative People Committee in Common is three fold:

- To oversee and receive assurance that the Trust level People Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

1.3 The overarching responsibilities of the Committee include:-

- Ensuring a People Strategy for the Collaborative is developed and aligned between the 4 organisations and meets the needs of the NHS People Plan
- Providing the Board in Common with assurance and oversight of all aspects of strategic people management and organisational development that is relevant for the Collaborative
- Provide the Board in Common with assurance of the implementation and delivery of the commitments detailed in the Trust's organisational People Strategies including the collaborative's progress in:-
 - Creating an excellent environment that attracts, retains and develops the best staff in the NHS, recognising and supporting the exceptional effort and dedication of our people, and provide resilience to workforce pressures across North West London;
 - Monitoring and supporting the development of a compassionate and inclusive culture; ensuring a safe environment which tackles the discrimination some staff face, thereby reducing inequalities
 - Monitoring and supporting the development of a positive and inclusive culture of staff engagement which ensures that staff feel involved, engaged, listened to and respected.
 - Working with the collaborative leadership to promote a safe environment for all staff and ensuring zero tolerance for bullying and harassment
 - Ensuring a sustainable workforce is in place to support the Collaborative and issues are shared and mutual support offered and that workforce transformation takes place where relevant
 - Seeking assurance that Trust plans are in place to look after and investing in the physical and mental health and wellbeing of the Collaborative workforce and where relevant develop a collaborative strategy

2. Specific Duties and Responsibilities

- To oversee and provide assurance that the Trust level People Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - Assist the Board in Common in ensuring that the capacity, capability and experience of people working across the Collaborative to provide care to patients is improving and developing to eradicate health inequalities across North West London.
 - Review the People Dashboard for the Collaborative and query any special cause variation in provider outcomes to seek assurance or to give advice on remedial actions that can be taken to improve performance. Escalate any risks/concerns and successes to the Board in Common as appropriate or refer back to the Trust People Committee.
 - Promote within the Collaborative a culture of open and honest reporting of any situation that may adversely affect the experience of staff working in the Collaborative
 - Seek assurance that effective mechanisms are in place to allow staff to raise concerns
 - Ensure the Collaborative's and Trust's activities are systematically and effectively promoting health and wellbeing, and psychological safety of the workforce.
 - Seek assurance from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians, Health and Wellbeing Guardians and other sources.
 - Ensure engagement and consultation processes with staff, stakeholders and communities reflect the ambition and values of the Collaborative and also meet statutory requirements
 - Review the Collaborative's position against the gender and ethnicity pay gap and ensure that the collaborative is seeking to reduce this over time by gaining assurance from the 4 Trusts that they have developed appropriate policies and actions
 - Review the Collaborative's progress via the Trusts with the Workforce Race Equality Standard and Workforce Disability Equality Standard, aiming to have fair and adequate workforce representation at all levels across the Collaborative
 - Review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the Committee's purpose and function.
- To oversee and assure collaborative-wide interventions for short and medium term improvements
 - Ensure that the Collaborative has a comprehensive Senior Leadership Development and Talent Management Programme in place designed to reinforce the culture the Collaborative is seeking to achieve, enable effective succession planning at senior levels and evaluate the effectiveness of the programme to inform further improvements.
 - Development of a staff passport and associated technologies that simplify how staff work across our sites and move employment between our hospitals - moving towards a life-time employment model within NW London that meets people's needs at different times in their life
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
 - ensure that the People Strategy and ED and I Strategy is continually meeting the needs of its workforce and the patients we serve.

- Ensure that the Collaborative has oversight of the Education, Skills and Capability agenda at Trust level and that this is shaped to meet the needs of the changing workforce. Ensure that acute issues are escalated as appropriate through the Integrated Care System to help influence change.
- Seek assurance as to the strategic development of the workforce including Collaborative approaches to :-
 - National and international recruitment
 - Approaches to improve retention
 - Approaches to improve staff satisfaction
 - Unified approaches to bank and agency management
 - Optimising back-office functions to improve quality and value for money

3. Composition

Membership

3.1 The members of the Committee are appointed by the Boards and will be made up of:

- A Vice Chair of the Board in Common as the Collaborative Committee Chair
- Non-executive Director Chairs of Local Provider People/Workforce Committees
- Lead CEO for People/Workforce for the Collaborative

3.2 The lead CEOs Trust will provide secretariat support to the Committee.

3.3 An open invitation stands for the Directors of People/Chief People Officers of the 4 Trusts in the Collaborative to attend the meeting.

3.4 The Collaborative Chair in Common may attend any meeting of the Committee. At the invitation of the Committee Chair, other executive directors, senior managers or non-executive directors may also attend the Committee meetings.

4. Meeting arrangements

4.1 Members of the Committee are expected to attend meetings wherever possible. At the invitation of the Committee Chair, others may also attend Committee meetings.

4.2 The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

4.3 The Committee will meet in common (including by telephone or video conferencing) at least four times a year or as determined by the Committee Chair. Any member of the Committee can ask for a meeting to be convened in person, by video-conference or by telephone, or for a matter to be considered in correspondence.

4.4 The quorum for meetings is 3 Members, 2 Non-executive Directors and the CEO Lead or their designated deputy. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.5 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers shall be circulated to each member of the Committee and where relevant, any other person required to attend, no later than five working days before the date of the meeting.

4.6 The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

4.7 Draft minutes will be sent to the Committee Chair within four business days of the meeting and submitted for formal approval at the next meeting.

5. Declarations of Interest

5.1 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

5.2 Any member at any time is entitled to ask the Chair whether an item of business should be discussed outside of a meeting in common, as it conflicts with a power or duty of an individual organisation.

6. Other duties

6.1 The Committee will discuss any matter which any member of the Committee believes to be of such importance that it should be brought to the attention of the Committee.

6.2 Where the Committee considers an item of its business may give rise to a potential conflict by meeting in common, the Committee may refer that business to the local provider Trust People/Workforce Committee.

7. Reporting responsibilities

7.1 The Committee's Chair will report formally to the Board in Common on its proceedings after each meeting.

7.2 The Committee will make whatever recommendations to the Board in Common that it deems appropriate in any area within its remit where action or improvement is required.

7.3 The Committee will receive escalation reports from local provider People/Workforce Committees.

8. Other matters

The Committee will:

8.1 have access to sufficient resources to carry out its duties, including access to the Directors of Corporate Governance/Corporate Affairs for assistance as required;

8.2 consider any other matters where requested to do so by the Board in Common and Local Provider People/Workforce Committees within the NWL Acute Provider Collaborative; and

8.3 review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

9. Authority

The Committee is authorised:

9.1 to seek any information it requires, or request attendance at a meeting, from any employee within the Collaborative to perform its duties;

9.2 to obtain, at the Collaborative's expense, outside legal or other professional advice on any matter within its terms of reference (subject to budgets agreed by the Board).

North West London Acute Provider Collaborative Infrastructure and Capital Collaborative Committee Terms of Reference

1. Overarching Purpose

- 1.1 The Infrastructure and Capital Collaborative Committee is a non-statutory standing sub-committee of the North West London Acute Collaborative Board in Common and is established to provide and assurance to the Board in Common (BiC) on the development and implementation of estate and digital infrastructure strategies across the Collaborative within defined and prioritised capital funding resources.
- 1.2 The overarching role of the Infrastructure and Capital Collaborative Committee in Common is three-fold:
- To oversee and receive assurance that the Trust level processes governing Estates and Digital are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response
 - To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
 - To prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements in the management of estate and digital infrastructure
- 1.3 The Infrastructure and Capital Collaborative Committee carries overarching responsibilities for:
- Considering, advising and governing the overarching Estate Strategy for the Collaborative ensuring the alignment of estate priorities across the Collaborative and the identification of estate related dependencies arising from changes to service/system operating models.
 - Providing the BiC with assurance and oversight of the planning and delivery of major infrastructure programmes across the Collaborative including involvement in the approval of relevant business cases
 - Overseeing and assuring the development of an information and IT strategy for the Collaborative that incorporates the delivery of a robust digital infrastructure and the development and deployment of a standard approach to digital.
 - Considering and contributing to the development of a capital prioritisation framework for the Collaborative.

2. Specific Duties and Responsibilities

- 2.1 The Infrastructure and Capital Collaborative Committee shall oversee and provide assurance to the BiC on the following areas:
- To oversee and provide assurance that the Trust level processes governing Estates and Digital are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.

- The consideration of estate impacts resulting from proposed service changes and/or developments including involvement in relevant business case review.
 - The effectiveness of contingency planning across the Collaborative to address estate failure and risk.
 - The commonality and rational variation in local digital investments to support the simplification of technology for staff across the Collaborative.
 - The robustness of the digital infrastructure across the Collaborative, including networks, data centres, digital security and arrangements for information governance.
- To oversee and assure collaborative-wide programmes of work that aim to provide short and medium term improvements
 - The implementation of the shared Cerner instance, moving towards common use and reporting, prioritising developments with Cerner to optimise user experience, and overseeing the application of a “Cerner first” approach and decisions to deviate from that.
 - The development and deployment of a standard operations management, reporting and command centre solution across the Collaborative.
 - Ensuring necessary engagement in the development of capital prioritisation framework for the Collaborative.
- To prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
 - The development of a collaborative-wide Information and IT Strategy
 - The development and implementation of a digital patient engagement strategy that addresses all connectivity needs with patients outside our hospitals.
 - The development and delivery of an overarching Estate strategy for the Collaborative ensuring alignment with individual local plans including redevelopment proposals.
 - The development and delivery of the overarching Sustainability Plan for the Collaborative

3. Composition

Membership

3.1 The members of the Committee are appointed by the Boards and will be made up of:

- A Vice Chair of the Board in Common as the Collaborative Committee Chair
- 2 further Non-executive Directors
- Lead CEO for Estates and Digital for the Collaborative
- Directors of Strategy from each Trust or equivalent
- Chief Information Officer, NWL ICS
- Director of Estates representative for the Collaborative (to be nominated by colleagues)
- Chief Financial Officer representative for the Collaborative (to be nominated by colleagues)

Others may be invited to attend depending on the focus of the discussions at the discretion of the Chair.

3.2 The Trust Secretary at Hillingdon Hospitals NHS FT or their nominee will act as the secretary to the Committee.

4. Meeting Arrangements

Attendance

4.1 Members of the Committee are expected to attend meetings wherever possible. In exceptional circumstances and subject to prior approval from the Chair of the Committee, a deputy can attend.

4.2 The Collaborative Chair in Common is entitled to attend any meeting of the Committee.

4.3 Any Non-Executive Director who is not a member of the Committee is entitled to attend Committee meetings. At the invitation of the Committee Chair, others may also attend the Committee meetings.

4.4 The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Meetings

4.5 The Collaborative Committee will meet (including by telephone or video conferencing) at least four times a year, or as determined by the Committee Chair. Any member of the Committee can ask for a meeting to be convened in person, by video conference or by telephone, or for a matter to be considered in correspondence/e governance.

4.6 The quorum for meetings is 50% of the membership, including

- At least 2 Non-executive Directors
- Lead CEO for Estates and Digital from the Collaborative

4.7 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed shall be circulated to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members, and to other attendees as appropriate no later than five working days before the date of the meeting.

4.8 The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

4.9 Draft minutes shall be sent to the Committee Chair within four business days of the meeting and submitted for formal agreement at the next meeting.

5. Declaration of Interest

5.1 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting.

6. Reporting responsibilities

6.1 The Committee's Chair shall report formally to the Board in Common on its proceedings after each meeting.

6.2 The Committee will make whatever recommendations to the Board in Common it deems appropriate in any area within its remit where action or improvement is needed.

7. Other matters

The Committee will:

7.1 have access to sufficient resources to carry out its duties,

7.2 consider any other matters where requested to do so by the Board in Common and Local Provider Boards within the NWL Acute Provider Collaborative

7.3 review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

8. Authority

The Committee is authorised:

8.1 to seek any information it requires, or request attendance at a meeting, from any employee or any other person in order to perform its duties;

8.2 to obtain, legal or other professional advice on any matter within its terms of reference, subject to Board in Common approval.

**North West London Acute Provider Collaborative
Nominations and Remuneration Collaborative Committee
Terms of Reference**

1. Purpose

1.1 The North West London Acute Provider Collaborative has established a Nomination and Remuneration Committee (the Committee) as a non statutory committee of the Board in Common to support the exercise of the respective duties and powers of the Boards of the 4 acute provider Trusts in their responsibilities. These include:

Remuneration aspects:

1.1 ensuring that the collaborative have a single formal and transparent remuneration policy

Nomination aspects:

1.3 assisting the Board in Common in ensuring that it maintains an appropriate structure, size, and balance of executive skills to support the strategic objectives of the Collaborative

2. Composition

Membership

2.1 Members of the Committee are appointed by the Board in Common and will be made of four Vice Chairs or their nominees amongst other NEDS representing the 4 acute provider Trusts plus the Chair in Common and the CEOs or their nominee and Chief People Officers of each Trust.

Committee Chair

2.2 The Committee will be chaired by the Chair in Common of the Collaborative or their nominee amongst the Vice Chairs.

2.3 The secretariat for the committee will be provided by the Corporate Governance Teams within the Collaborative.

3. Meeting arrangements

Attendance

3.1 Members of the Committee are expected to attend meetings wherever possible. At the invitation of the Committee Chair, others may also attend Committee meetings.

3.2 The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

3.3 The Committee will meet in common (including by telephone or video conferencing) as determined by the Committee Chair but at least once a year. Any member of the Committee can ask for a meeting to be convened in person, by video-conference or by telephone, or for a matter to be considered in correspondence.

3.4 The quorum for meetings is the Chair in Common or their nominee amongst the Vice Chairs plus 4 non-executive directors (1 representing each Trust in the Collaborative), and 4 Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

3.5 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers shall be circulated to each member of the Committee and where relevant, any other person required to attend, no later than five working days before the date of the meeting.

3.6 The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

3.7 Draft minutes will be sent to the Committee Chair within four business days of the meeting and submitted for formal approval at the next meeting.

4. Declarations of Interest

4.1 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion.

4.2 Any member at any time is entitled to ask the Chair whether an item of business should be discussed outside of a meeting in common, as it conflicts with a power or duty of an individual organisation.

5. Remuneration related duties

The Committee will

6.1 Recommend to the respective Nomination and Remuneration Committees of each Trust the framework and policy for the remuneration of the Chief Executive Officers and Executive Directors of the Collaborative

6.2 In determining such policy, take into account all factors which it deems necessary including relevant legal and regulatory requirements, Treasury guidance and other best practice as appropriate. The objective of such policy shall be to ensure that Chief Executives and Executive Directors are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the collaborative; and that there is a consistent approach taken across the Collaborative.

6.3 Review and note annually the remuneration trends across the NHS. In doing so, obtain reliable, up-to-date information about remuneration in other organisations similar to the Collaborative. The Committee shall have full authority to commission any reports or surveys which it deems necessary to help fulfil its obligations.

6.4 In relation to senior level appointments, keep succession planning and senior capability across the Collaborative under continuous review including the size and composition of the Trusts Executive Teams

6.5 Recommend to the respective Nomination and Remuneration Committees of each Trust the framework and policies relating to early termination payments for Executive Directors, ensuring consistency in approach across the Collaborative.

6.6 Ensure a consistent approach is taken with regard to Clinical Excellence awards across the Collaborative.

6.7 Seek assurance that progress is being made at Trust level on the gender and ethnicity pay gaps.

7. Nominations related duties

7.1 Form plans for succession of Chief Executives and other Executive Directors within the collaborative.

7.2 Before any appointments are made to Executive positions, and to support the strategic direction of the Collaborative, seek assurance that an evaluation of the balance of required skills, knowledge, experience and diversity has taken place and agree upon a description of the role and capabilities required for a particular appointment/re-appointment.

8. Other duties

8.1 The Committee will discuss any matter which any member of the Committee believes to be of such importance that it should be brought to the attention of the Committee.

9. Reporting responsibilities

9.1 The Committee's Chair will report formally to the Board in Common, in private session, on

its proceedings after each meeting.

10. Other matters

The Committee will:

10.1 have access to sufficient resources to carry out its duties, including access to the Directors of Corporate Governance/Corporate Affairs for assistance as required;

10.2 consider any other matters where requested to do so by the Board in Common or local provider Nomination and Remuneration Committees; and

10.3 review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

11. Authority

The Committee is authorised:

11.1 to seek any information it requires, or request attendance at a meeting, from any employee within the Collaborative to perform its duties;

11.2 to obtain, at the Collaborative's expense, outside legal or other professional advice on any matter within its terms of reference (subject to budgets agreed by the Board).

4. Integrated Performance, Quality and Workforce Report

Discussion Item Speaker: CEO Workstream Leads Time: 10.05

References:

- Enc 06 (1). NWL BiC Integrated Performance Report coversheet - October2022.pdf
- Enc 6 (2). NWL Acute Collaborative Board in Common- integrated performance report 18 October 2022 V2
- Enc 06 (3). NWL Acute Collaborative - Operational Performance report 20 Sept 2022_ Final draft v1.pdf
- Enc 06 (4). Appendix 1_CCICFP V2.pdf
- Enc 06 (5). Appendix 2_CCICFP V2.pdf
- Enc 06 (6). Appendix 3_CCICF&P.pdf
- Enc 06 (7). Appendix 4_CCICF&P.pdf
- Enc 06 (8). Clinical Outcomes - v1.pdf
- Enc 06 (9). NWL ICS Strategic Reporting Pack - People Performance - PP - Final.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 4.0

This report is: Public

Integrated Performance Report

Author: Tim Orchard, Pippa Nightingale, Lesley Watts, Patricia Wright
Job title: Chief Executive Officers

Accountable director: Tim Orchard, Pippa Nightingale, Lesley Watts, Patricia Wright
Job title: Chief Executive Officers

Purpose of report

Purpose: To provide assurance that performance across the quality, workforce and core operational standards domains are being monitored and that appropriate action is being taken to assess variance from agreed standards.

The Board in Common is asked to note the reports.

Report history

The individual reports have been considered at the relevant Trust committees and the Collaborative assurance committees during Sept 2022.

Executive summary and key messages

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

The aim is to produce a consolidated integrated performance report for the acute collaborative that provides assurance that the individual trusts and the acute collaborative are providing high quality, safe and effective care, and that in doing due consideration has been given to the experience of its workforce and population served.

This report to the Board in Common represents the first cycle of an evolving report that will be refined over the next few months to ensure it provides a balanced view of performance of sufficient granularity to ensure the Board is sighted, and can take action on, areas of concern.

The information in this report brings together the information from three separate reports attached as appendices covering a range of indicators that have been drawn from the Trust integrated performance reports and agreed by the lead Chief Executive for each area of performance and highlights areas of good practice and areas of concern.

Strategic priorities

Tick all that apply

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

Impact assessment

Tick all that apply

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

Reason for private submission

Tick all that apply

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

N/A



Chelsea and Westminster Hospital
NHS Foundation Trust



The Hillingdon Hospitals
NHS Foundation Trust



Imperial College Healthcare
NHS Trust



London North West
University Healthcare
NHS Trust

NWL Acute Collaborative Board in Common

Integrated Performance report

Executive Summary – Integrated Performance report

This report to the Board in Common represents the first cycle of an evolving report that will be refined over the next few months to ensure it provides a balanced view of performance at a sufficient level of granularity to ensure the Board is sighted, and can take action on, areas of concern. The information in this report brings together the information from three separate reports (attached as appendices) covering a range of indicators that have been drawn from the Trust integrated performance reports and agreed by the lead Chief Executive for each area of performance.

The executive summaries in the next 3 slides detail progress with developing the performance reports and highlight areas for escalation to the Board in Common. The work to date has demonstrated that individual trusts, although broadly monitoring the same key performance indicators, use different reporting formats and different targets which makes comparison at a collaborative level difficult. This will be resolved in the next cycle of reporting. However, some insights can be drawn from the information presented and is set out below.

Overall, the four trusts in the acute collaborative perform well when benchmarked with other trusts and Integrated Care Sectors (ICSs) in London. However, there is considerable variation in quality and operational performance between the trusts which is being addressed through the Elective, Emergency and Cancer Care Boards and monitored through the Acute collaborative executive committee. Quality performance will be monitored through an executive Quality Board supported by Clinical reference groups. All of these groups have identified key priorities for action when performance is below the expected standards and specific area areas of concern are addressed through trust internal incident investigation processes and through deep dives where there is learning that can be shared across the 4 trusts.

In this quarter, increasing levels of sickness absence, increasing levels of voluntary turnover and high levels of vacancies with specific hard to recruit roles and gaps have the potential to impact on the trust and collaborative preparedness and planning for winter and there is already some evidence of this in relation to elective and emergency performance and cancer waits. However, based on the data available, this does not appear to be having any immediate impact on quality of care at a trust level, although it will be important to monitor patient experience and clinical incidents closely. Robust winter plans have now been agreed and additional funding has been approved by the ICS to support winter schemes (particularly additional beds) to improve emergency flow and protect elective delivery.

Executive Summary

The quality metrics and reporting methodology were agreed following a detailed review of the trust board scorecards, national guidance and CQC insight reports. This first acute collaborative dashboard presents data in statistical process control (SPC) charts for each Trust which allows comparison over time however in their current form they are not as useful for comparing cross trust, a key requirement for this board in common. Work has commenced to agree targets, compare to benchmarked data where available and set improvement trajectories where appropriate. This will inform the dashboards for the next reporting cycle.

The dashboard was not available for presentation to the individual trust quality committees and so a bespoke process was used to allow presentation to this board in common. Quality function reports were reviewed for each Trust at the first collaborative quality committee and variance in the data discussed. Assurance was gained at the committee that action plans are in place for all areas of variance.

A process was approved at the Acute collaborative quality committee which will ensure this dashboard is reviewed alongside Trust scorecards through the quality governance structures and function reports. A template for Trusts to use to report is now being agreed to ensure standardisation.

Five priority work streams for quality have been agreed across the collaborative. A key part of these is to determine how we measure and report clinical outcomes. The outputs from these work streams will be reviewed alongside the dash board metrics at the collaborative quality committee in March with any recommendations to amend the dash board in advance of the new financial year. A number of areas of variance in the data align to these priorities.

Escalations by Theme:

- Following detailed review at the Acute collaborative quality committee assurance was gained that areas of variance are being managed through Trust governance processes. There were no issues to escalate to the board in common.

Executive Summary - People

Vacancy rates at collaborative level are a common cause variation within the upper process limit albeit with hit and miss target achievement and variation at Trust level. Across the Acute Collaborative are currently at 11.4% and have been slowly increasing since April 2022, correlating to a rise in staffing turnover levels as well as establishment changes through budget setting for 2022/23.

Voluntary turnover has been increasing across all Trusts for the past six months and is a special cause concern variation and, with the exception of LNWUH, is over target at Trust level; a trend also reflected in other industries. As we approach winter, and its associated pressures on staffing through activity and sickness, reducing turnover levels where possible through increased retention is of priority.

The past 12-months has seen a continued increase in the rolling sickness absence rate and is a special cause concern for the Collaborative with impacts of COVID absence and Monkey Pox on staffing absence. July 2022 saw increased levels of sickness, due to higher levels of COVID illness; all staffing groups were affected with particular impact across nursing & midwifery and medical staffing with some services and theatre lists being cancelled due to lack of staff.

We are currently working towards an Acute Collaborative target for this measure with two Trusts currently reporting this against local target; Imperial at 2% and LNWUH at 4%

Completion rates, for both non-medical and medical Performance Development Reviews (PDR) and appraisals, is an area of concern with no Trust meeting target for both measures and we are currently working towards an agreed Acute Collaborative target for both of these measures to drive improvement

All Trusts across the collaborative perform well against their individual targets for Core Skills compliance but we are starting to see a reduced overall Collaborative position

The committee reviewed the themes from each trusts WRES annual reports and action plans.

Escalations by Theme:

- Increasing levels of sickness absence
- Increasing levels of voluntary turnover
- High levels of vacancies with specific hard to recruit roles and gaps
- Trust and Collaborative preparedness and planning for winter

Executive Summary – Operational Performance

Executive Summary:

Forty two lead indicators have been identified by the Operational leads as providing good assurance of performance across the three main areas of operational delivery: **urgent and emergency care (UEC); elective care (inc. diagnostics) and cancer care. Seventeen** of these have been brought together in this reporting pack and the remaining indicators are contained within the ICS data packs attached at appendices 1-4 in the main pack. Further refinements to the reports will be made in the next reporting cycle. The report is grouped into the three main areas of operational delivery commencing with a summary slide and followed by the individual indicators displayed as a set of trust, and where relevant, collaborative charts with associated commentary.

Operational performance is monitored at Trust and Sector level through operational, assurance and system boards. There is shared learning across the three main areas of operational delivery and national best practice is adopted where appropriate, but performance across a number of pathways is below national and local expectations. Further work is underway to reduce variation through improved understanding of the drivers of performance.

Escalations by Theme:

- Elective delivery
- A&E waits
- 62 day GP to first treatment for cancer



Chelsea and Westminster Hospital
NHS Foundation Trust



The Hillingdon Hospitals
NHS Foundation Trust



Imperial College Healthcare
NHS Trust



London North West
University Healthcare
NHS Trust

NWL Acute Provider Collaborative Operational Performance

Executive Summary

Executive Summary:

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Escalations by Theme:

- Elective delivery
- A&E waits
- 62 day GP to first treatment for cancer

Elective Care Summary

Executive Summary:

There is medium confidence of delivering across the suite of elective KPIs (see slide 3 of Appendix 1 for the collective position and slides 23-26 for the individual trust position) with strong performance on the 78 week wait removal rate, the P2 waiting list size and outpatient (first) activity.

The number of patients waiting >52 weeks is significantly above target and growing, and elective total activity is below the 107% of 19/20 activity target. OP (Follow up -FU) activity is above plan and further work is required to increase the level of patient-initiated follow up (PIFU) to address this.

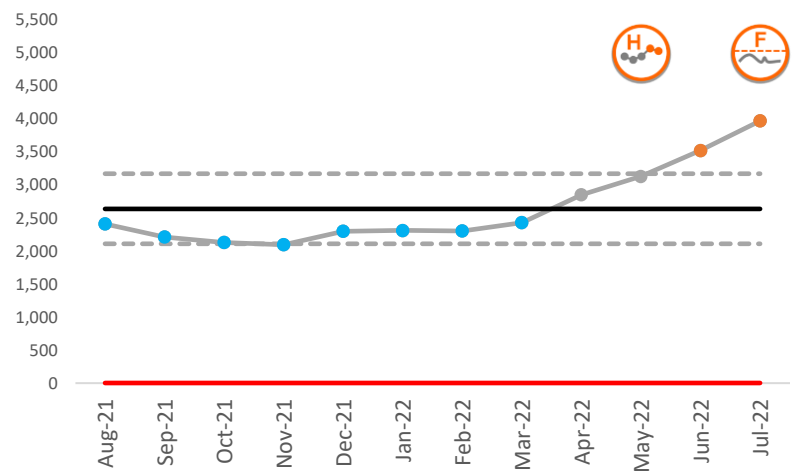
All trusts have developed plans to deliver (overall) to the 107% of 19/20 electivity activity as a minimum by year end although it is recognised that there are significant risks in achieving this.

Escalations by Theme:

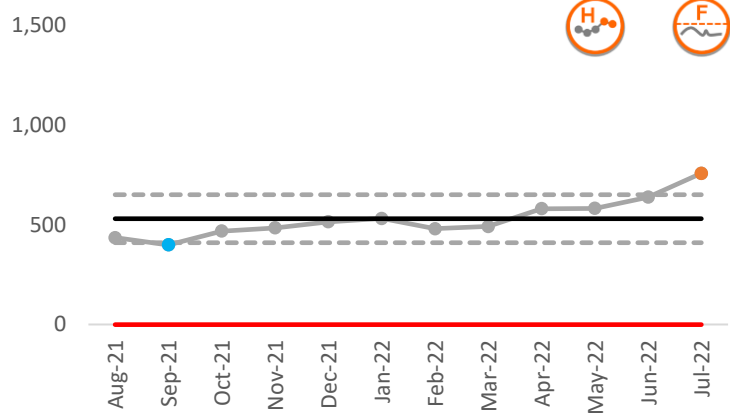
- Growing Patient Treatment List (PTL)

Metric: Patients waiting >52 weeks on RTT pathway
CQC Domain: Responsive
Month: July 2022
Target: tbc

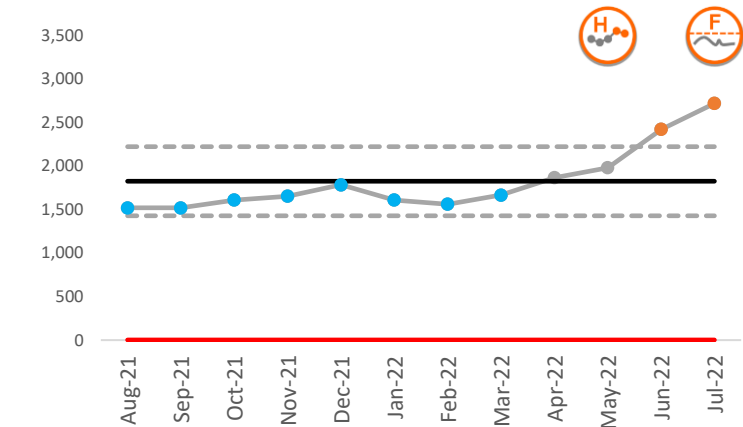
Patients waiting >52 weeks on RTT pathway - Sector



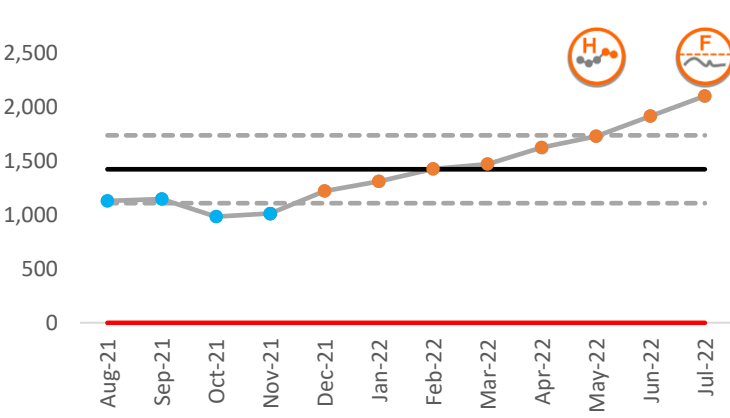
Patients waiting >52 weeks on RTT pathway - CW



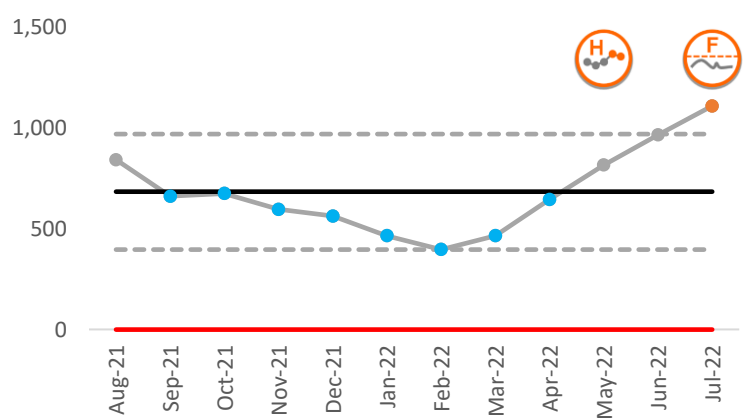
Patients waiting >52 weeks on RTT pathway - ICH



Patients waiting >52 weeks on RTT pathway - THH



Patients waiting >52 weeks on RTT pathway - LNW



Patients waiting >52 weeks on RTT pathway

Patients waiting >52 weeks on RTT pathway

Acute Provider Collaborative Summary:

The number of people waiting greater than 52 weeks on the RTT pathway remained stable overall until March 2022, but has been steadily increasing since then. The consolidated data hides considerable differences in numbers across the APC with THH being the biggest contributor to the increase. In part, growth relates to specific action to reduce the number of people waiting over 78 weeks, but further work is required to understand the differences in this cohort to ensure patients across the APC receive timely care.

Acute Provider Collaborative Actions:

APC actions: Review of long waiters in line with new mutual aid guidance (first submission 16 September then ongoing)

Trust actions:

CWFT: Trust is reviewing all 52-wk patients to ensure they have a next step on the care pathway. Additional capacity is being put on to ensure patients are seen in date and priority order. Text message campaigns and PIFU pathways being initiated for long waiting patients where clinically appropriate.

ICHT: undertaking a series of CEO led long waiter deep dives to support decision making in challenged areas. Agreement of pan London mutual aid for Allergy long waiting patients (in progress)

THH: Tech enabled validation review to commence for 5000 pathways over 40 weeks.

Independent sector support for long waits in Rheumatology and Pain.

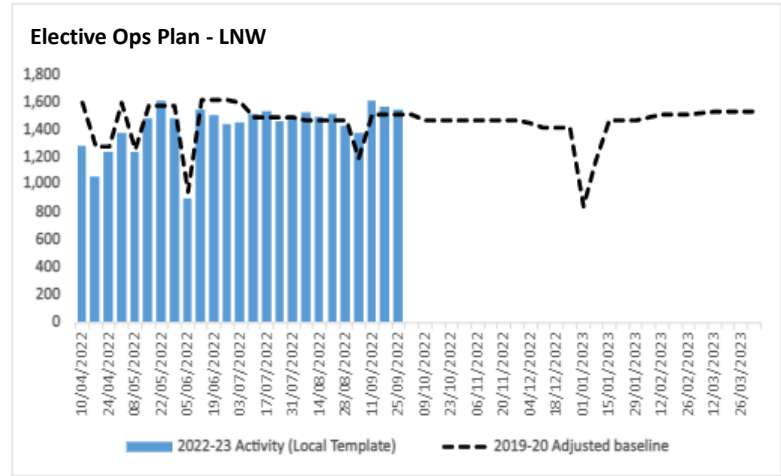
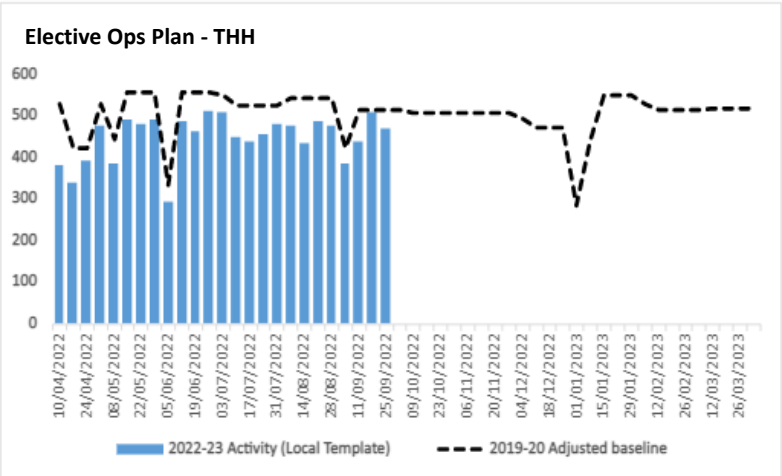
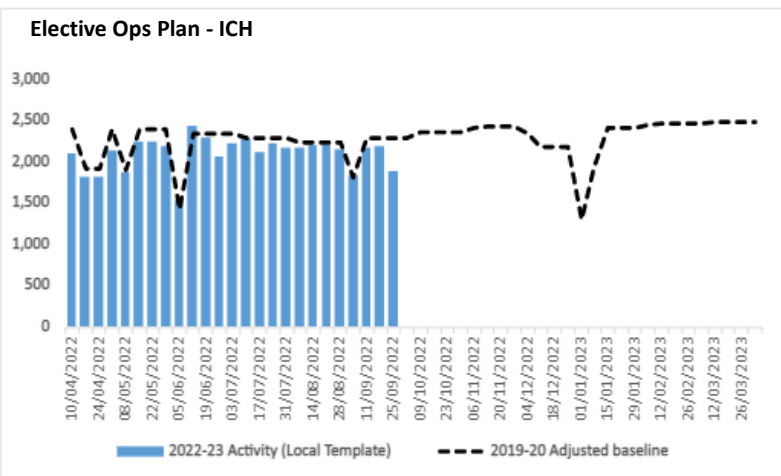
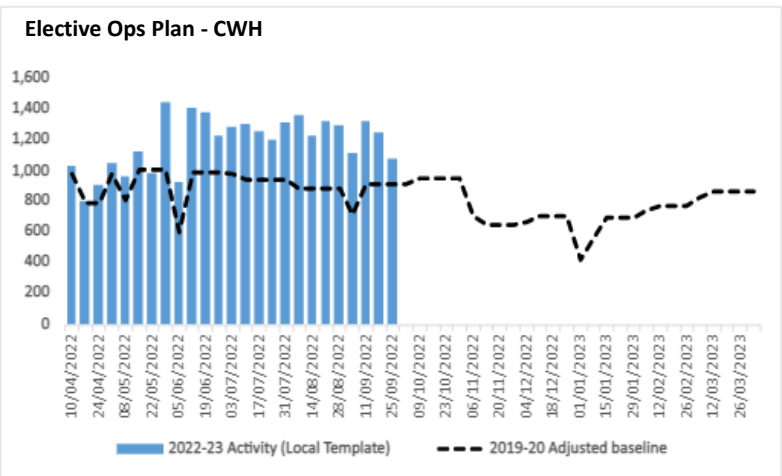
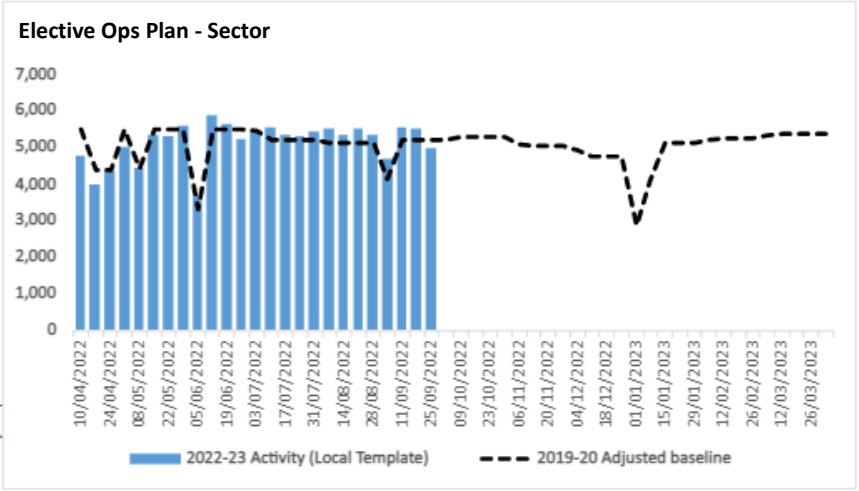
Patient by patient tracking of over 78 week waits.

LNW: Key focus on gynae waiting list validation as largest tip over area. Continued recruitment. Stricter management of DNAs in line with Access Policy.

Acute Provider Collaborative Assurance & Timescales for improvement

Each trust has an agreed reduction trajectory which is monitored through the local executive and assurance groups and the Elective Care Board.

Metric: Elective Ops Plan
CQC Domain: Responsive
Month: July 2022
Target: 107%



Elective Ops Plan

Elective Ops Plan

Acute Provider Collaborative Summary:

Delivery of the elective operating plan is below the 107% target although plans are now in place to deliver the plan (at aggregate level) by year end to ensure a reduction in patients waiting and full recovery of ERF.

A number of factors have impacted on delivery including theatre utilisation and availability of staff such as anaesthetists.

Acute Provider Collaborative Actions:

APC: All trusts have developed recover plans to achieve 107% overall by year end. Mutual aid and use of Independent sector being pursued where necessary

Trust actions:

CWFT: Elective Pre-op Covid screening pathway being developed with a view to having a pool of patients who can be added to cover last minute cancellations

THH: Increasing theatre activity/utilisation, perfect weeks planned for T&O and small number of additional WLIs.

ICHT: Super September – Initial plans for a range of enabling activities to accelerate improvement have been completed and now transitioning to implementation (at 09/09/22). These should help to drive elective recovery in admitted and non-admitted pathways as we move into autumn

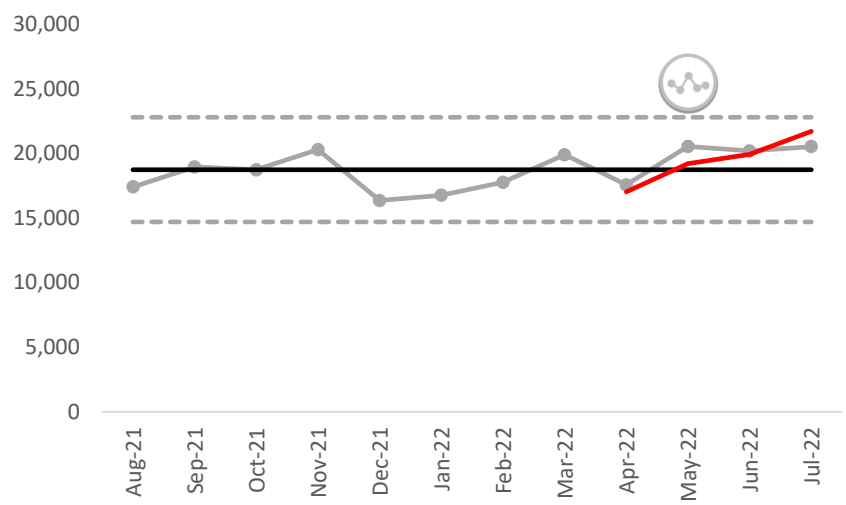
LNW: Theatres – increasing sessions from Sept and increasing utilisation. Risk remains on WLI uptake. Implementing digital POA solutions. Continued recruitment. Continuation of endoscopy recovery plan. Continued focus on RDA counting and coding

Acute Provider Collaborative Assurance & Timescales for improvement

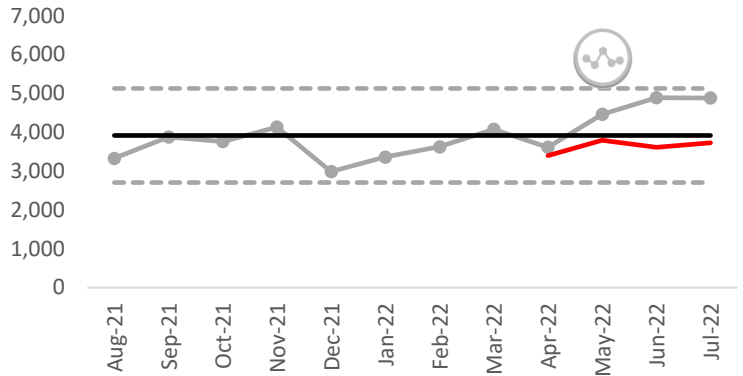
Each trust has an agreed activity trajectory which is monitored through the local executive and assurance groups and the Elective Care Board.

Metric: Daycase Ops Plan
CQC Domain: Responsive
Month: July 2022
Target: 107%

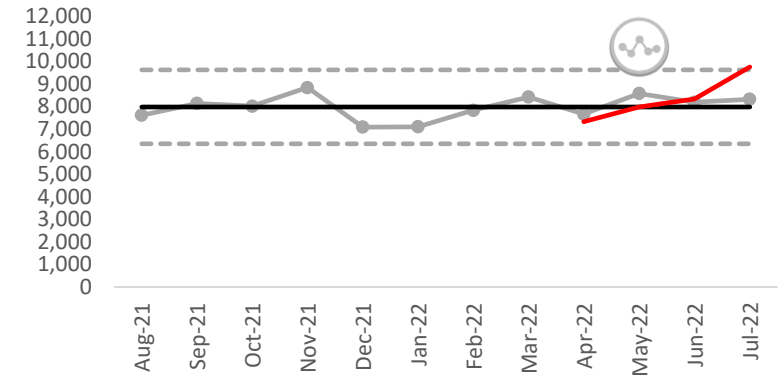
Daycase ops Plan - Sector



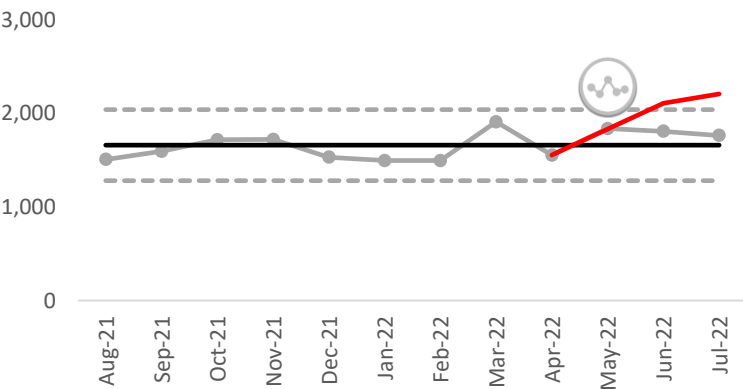
Daycase ops Plan - CW



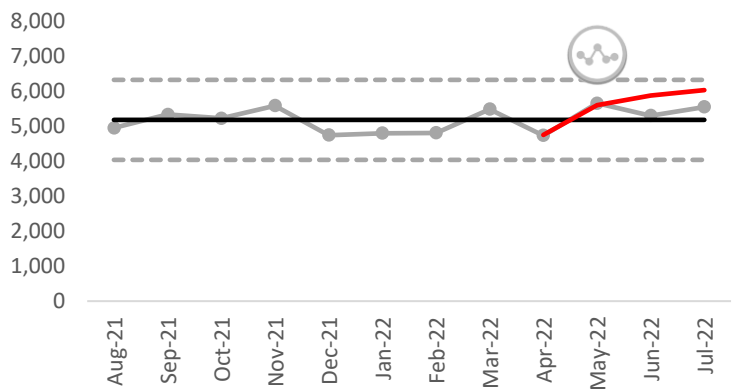
Daycase ops Plan - ICH



Daycase ops Plan - THH



Daycase ops Plan - LNW



Daycase Ops Plan

Daycase Ops Plan

Acute Provider Collaborative Summary:

Delivery of the elective operating plan is below the 107% target although plans are now in place to deliver the plan (at aggregate level) by year end to ensure a reduction in patients waiting and full recovery of ERF.

A number of factors have impacted on delivery including theatre utilisation and availability of staff such as anaesthetists.

The focus over the next few months is to drive up day case activity where possible to minimise need for inpatient beds over the winter months and maximise throughput.

Acute Provider Collaborative Actions:

APC: Mutual aid and use of Independent sector being pursued where necessary

Trust actions:

CWFT: New IPC guidance being reviewed and modified. Elective Pre-op Covid screening pathway being developed with a view to having a pool of patients who can be added to cover last minute cancellations

ICHT: Super September – Initial plans for a range of enabling activities to accelerate improvement now ready for implementation

THH: Additional lists in non theatre day-case specialities. Daily reporting of activity performance

LNW: . Continuation of endoscopy recovery plan. Continued focus on RDA counting and coding

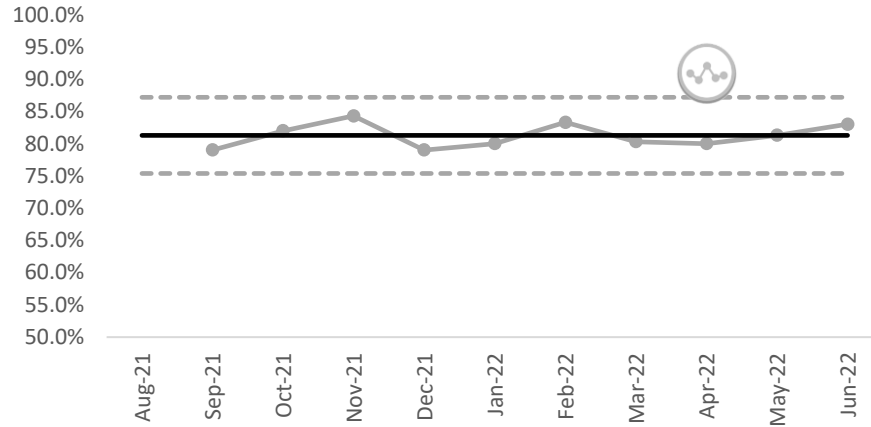
Acute Provider Collaborative Assurance & Timescales for improvement

Each trust has an agreed activity trajectory which is monitored through the local executive and assurance groups and the Elective Care Board.

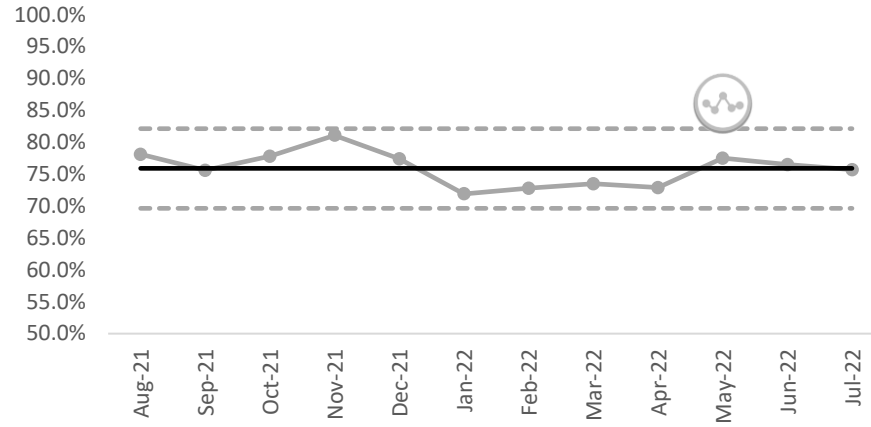
Metric: Theatre Utilisation Model Hospital
CQC Domain: Effective
Month: July 2022
Target: >85%

Theatre Utilisation Model Hospital

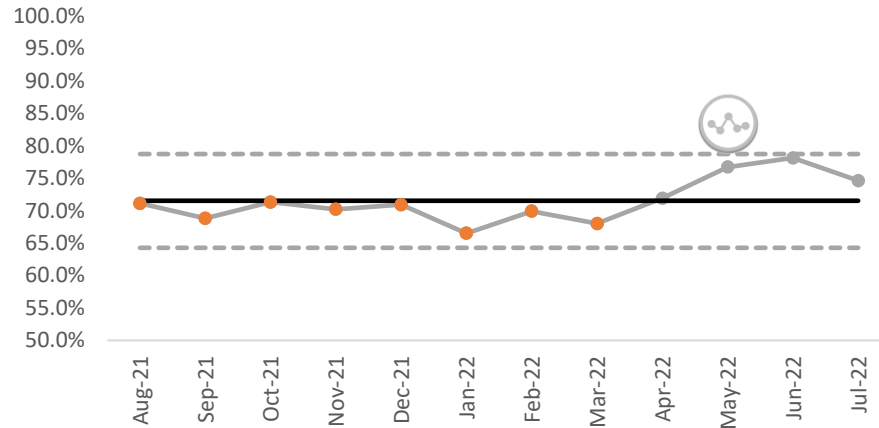
Theatre Utilisation Model - CWH



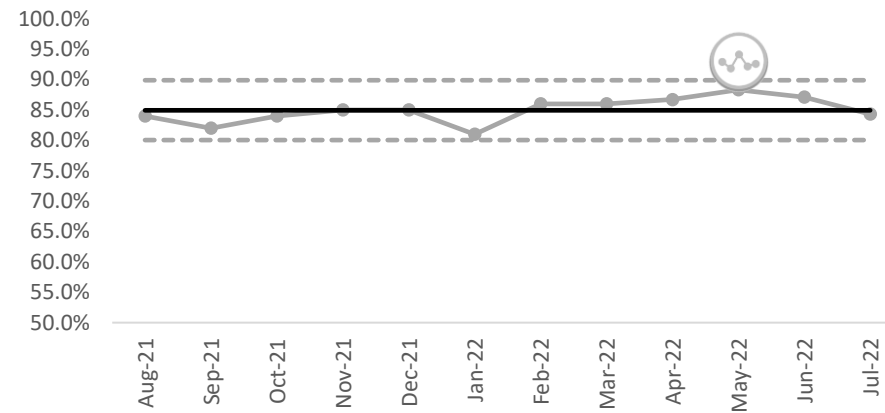
Theatre Utilisation Model - ICH



Theatre Utilisation Model - THH



Theatre Utilisation Model - LNWH



Theatre Utilisation Model Hospital

Acute Provider Collaborative Summary:

There is still scope for improvement in theatre utilisation across all four trusts which would support an increase in activity with minimal additional resource.

Further work is required to determine the maximum utilisation level possible at each trust site in light of theatre configuration, case mix etc.

Acute Provider Collaborative Actions:

Trust actions:

CWFT: Teams are focusing on turnaround times and reducing the current 23-minute average. Plans to implement to a holding bay, a floating anaesthetist and ODP are underway to support this initiative.

ICHT: A high level action plan is progressing to optimise planning and scheduling and reduce surgical backlogs. Eight of 15 specialties were at or above recovery trajectory in July.

THH: 6-4-2 monitoring of theatre lists, use of Palantir to improve bookings, sessional use and focus on late starts and early finishes.

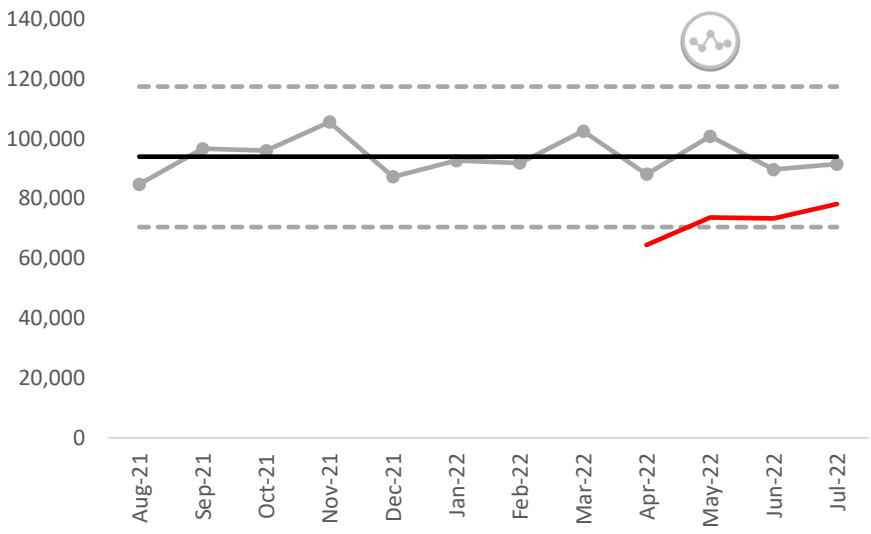
LNW: continued focus on improving utilisation through weekly performance meetings whilst increasing the number of delivered surgical sessions.

Acute Provider Collaborative Assurance & Timescales for improvement

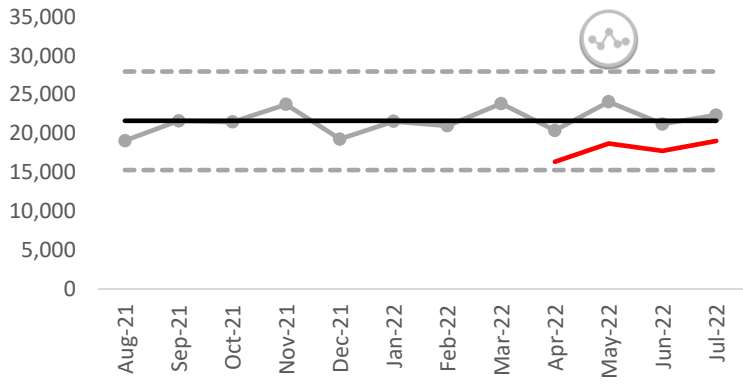
Monitored through the local executive and assurance groups and the Elective Care Board.

Metric: Outpatient First Appointment News
CQC Domain: Responsive
Month: July 2022
Target: >100%

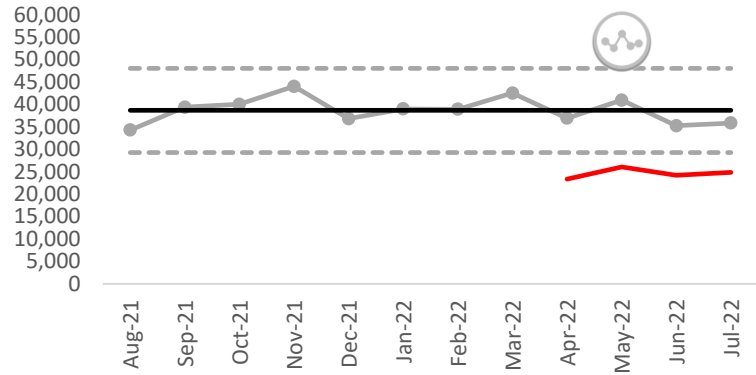
Outpatient First App News - Sector



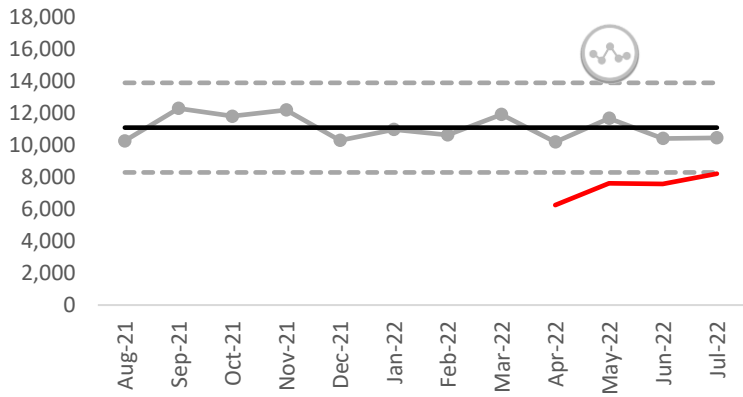
Outpatient First App News - CW



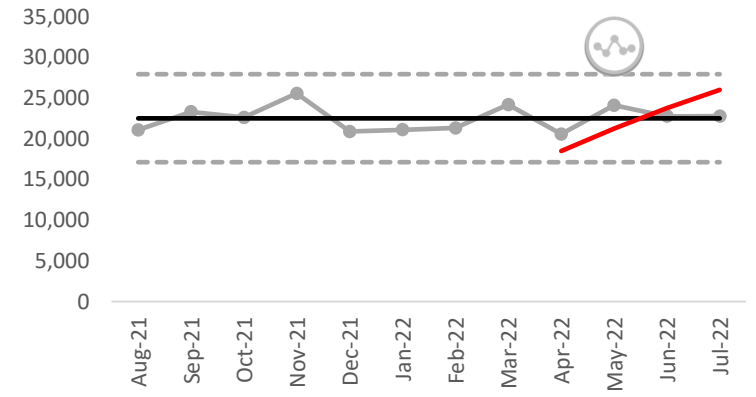
Outpatient First App News - ICH



Outpatient First App News - TTH



Outpatient First App News - LNW



Outpatient First Appointment News

Outpatient First Appointment News

Acute Provider Collaborative Summary:

Performance is ahead of target overall. Increasing rates of Advice and Guidance will ensure patients only those patients who require acute care are added to the waiting list.

Trust highlights (if any):

LNW: The Trust continues to experience a high number of 2WW referrals that requires further investigation.

Acute Provider Collaborative Actions:

Trust actions:

CWFT: Position as per plan

ICHT: Position as per plan

THH: Continuing with good A&G activity, increasing new appointments in those services with high non admitted backlog, focus on reducing DNAs and increasing completion of clinical outcomes.

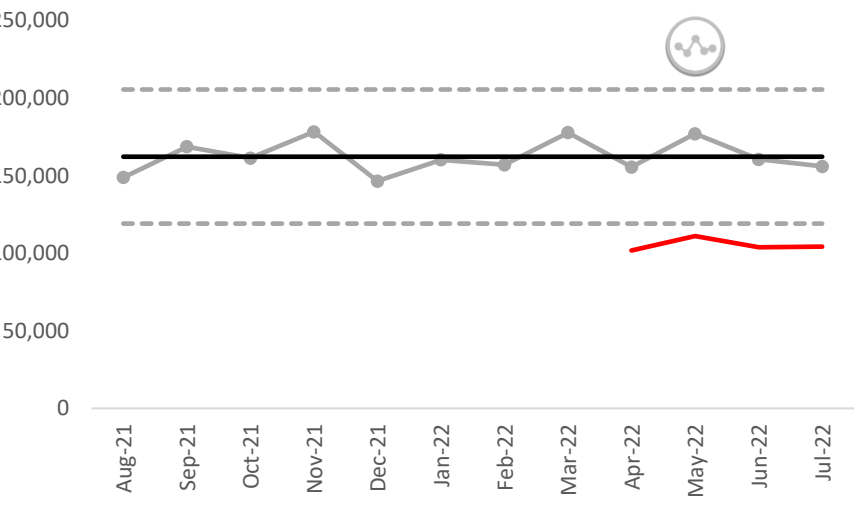
LNW: specific actions underway to cover 1. counting and coding, 2. advice and guidance, 3. reducing DNA rate, 4. overbooking on clinic templates

Acute Provider Collaborative Assurance & Timescales for improvement

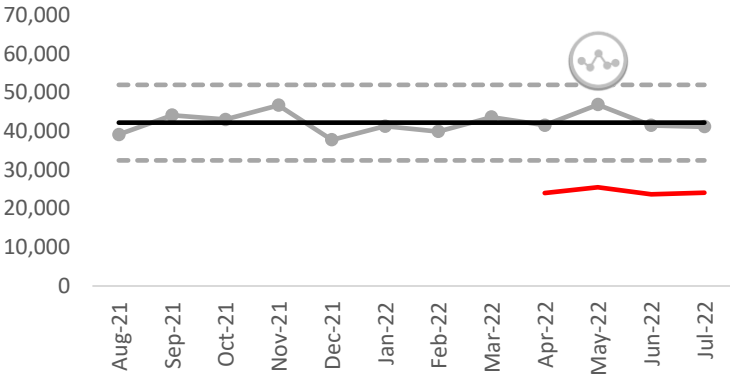
Monitored through the local executive and assurance groups and the Elective Care Board.

Metric: Outpatient Follow Ups
CQC Domain: Responsive
Month: July 2022
Target: <85% of 19/20

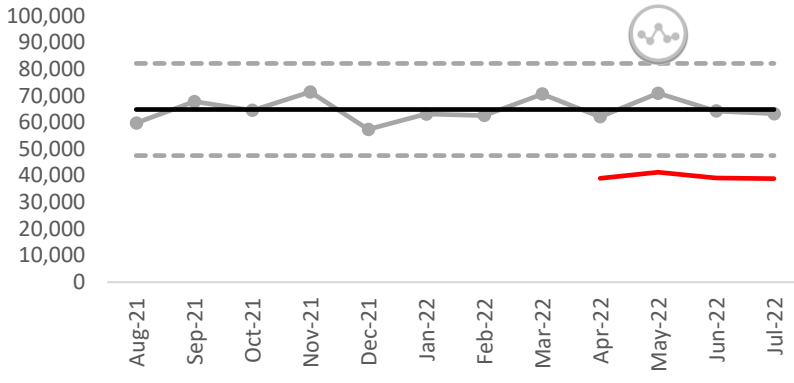
Outpatient Follow Ups - Sector



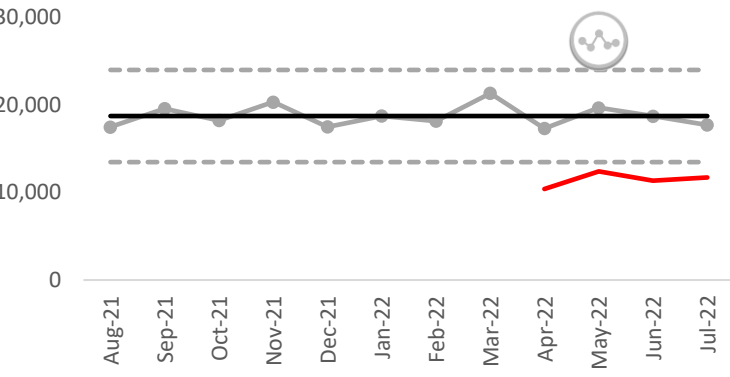
Outpatient Follow Ups - CW



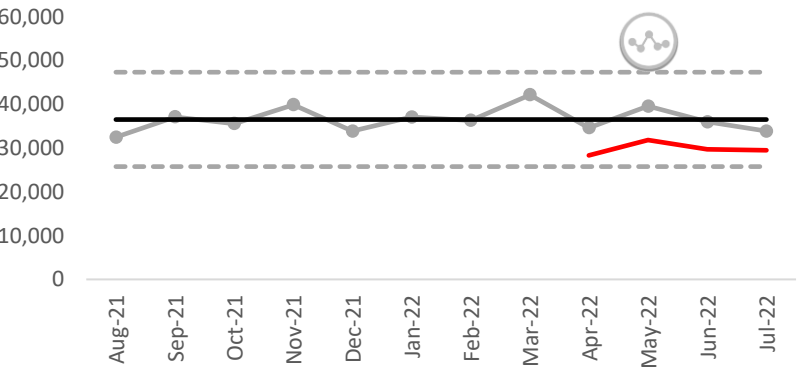
Outpatient Follow Ups - ICH



Outpatient Follow Ups - THH



Outpatient Follow Ups - LNW



Outpatient Follow Ups

Outpatient Follow Ups

Acute Provider Collaborative Summary:

All trusts have a follow up rate above 85% of 19/20 activity.

Acute Provider Collaborative Actions:

Trust actions:

CWFT: Work to reduce f/u activity and replace with new underway. Implementation of PIFU pathways expected to support reduced activity.

ICHT: Retrospective review of follow up patients for PIFU, review of follow-up DNAs in line with access policy

THH: Daily reporting of activity performance, increasing use of PIFU to reduce.

LNW: additional focus on PIFU to further reduce demand. Improving digital correspondence to improve DNA rates and support clinic utilisation.

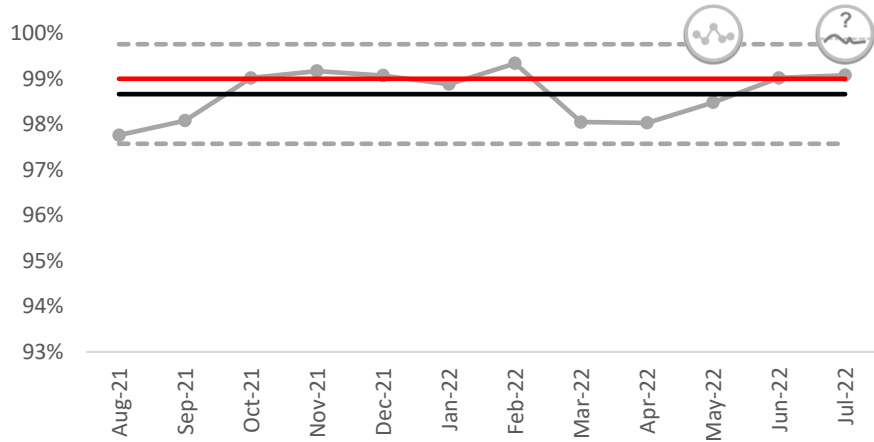
Acute Provider Collaborative Assurance & Timescales for improvement

Monitored through the local executive and assurance groups and the Elective Care Board.

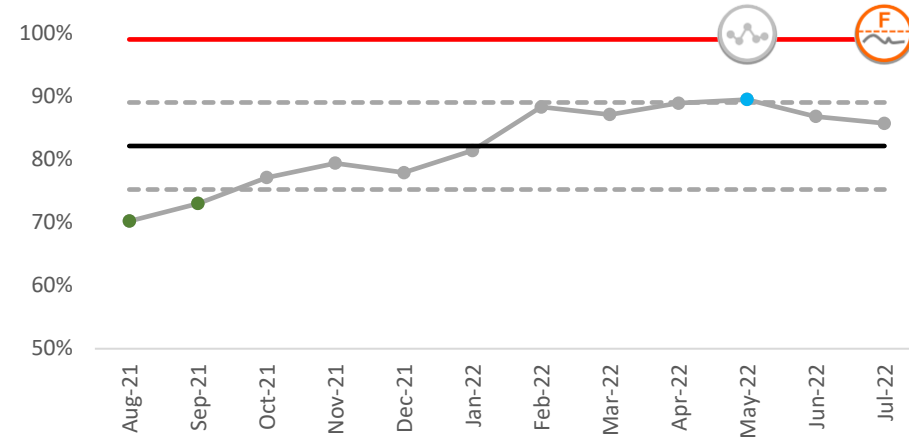
Metric: Diagnostic Waiting < 6 weeks
CQC Domain: Responsive
Month: July 2022
Target: >99%

Diagnostic Waiting < 6 weeks

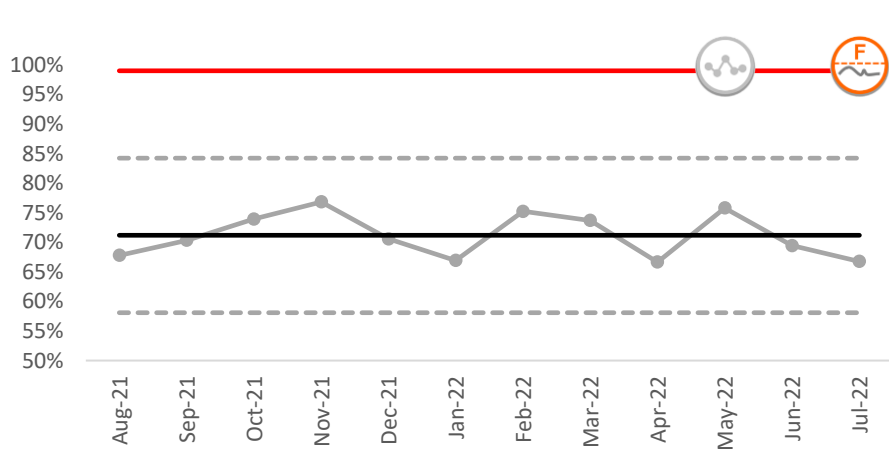
Diagnostic waiting times <6weeks - CWH



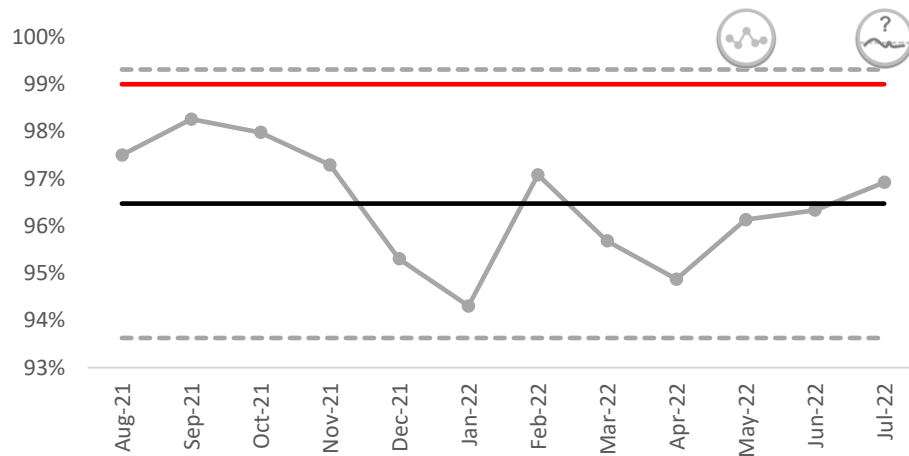
Diagnostic waiting times <6weeks - ICH



Diagnostic waiting times <6weeks - THH



Diagnostic waiting times <6weeks - LNWH



Diagnostic Waiting < 6 weeks

Acute Provider Collaborative Summary:

None of the Trusts are achieving the diagnostic wait target of <6 weeks, although all but THH are close to target.

Further detail on performance by modality and recovery actions are included in Appendix 2.

Trust highlights:

CWFT: The Trust has maintained performance by achieving this target in July 2022, at 99.08%, meaning 7,827 patients received their diagnostic test within 6 weeks across the 15 key areas

ICHT: Two areas, Imaging and Audiology, are contributing to over 80% of breaches. Paediatric service continues to experience on-going demand challenges following closure of community paediatric service

LNW: Trust ranked top quartile nationally.

THH: Challenges with meeting DM01, main modalities that contribute to the underperformance are Endoscopy and Echos.

Trust actions:

CWFT: no specific actions

ICHT: Recruitment and retention challenges in ultrasound are being addressed and the trust is also in the process of agreeing mutual aid for non-obstetric ultrasound. Within adult audiology, additional staff recruited and additional weekend clinics implemented. The paediatric audiology service continues to experience increased demand following closure of community paediatric service.

THH: Specific action plan for ECHOs and Endoscopy being worked through. Mutual aid in process of being agreed for USS and MRI.

LNW: The Trust continues recruitment campaigns for diagnostic staffing in line with plans to expand capacity for winter 2022 when additional diagnostic equipment will be on line.

Monitored through the local executive and assurance groups and the Elective Care Board.

Urgent and Emergency Care Summary

Executive Summary:

Urgent and emergency care performance is influenced by the rate of flow into hospitals and the rate of discharge. A range of indicators have been selected steps within the care pathway. Further information is provided in Appendix 3.

Overall demand for emergency care is higher than 2019-20 with consequent pressure on the front door. Growth in UTC demand (Appendix 3) has a knock on effect to A&E type 1 performance.

Delays to ambulance handover are closely scrutinised at ICS and Regional level and handover delays at Northwick Park are the biggest challenge across the Acute collaborative.

The percentage of patients spending more than 12 hours in A&E was a new indicator introduced during 2021-22. There is huge variability in this metric on a daily basis with rates below 5% in less acute units and up to around 12% in more acute units. The exception to this is C&W and WMUH where time in the department is consistently low. The lower figures shown in the follow charts reflects the combined trust data.

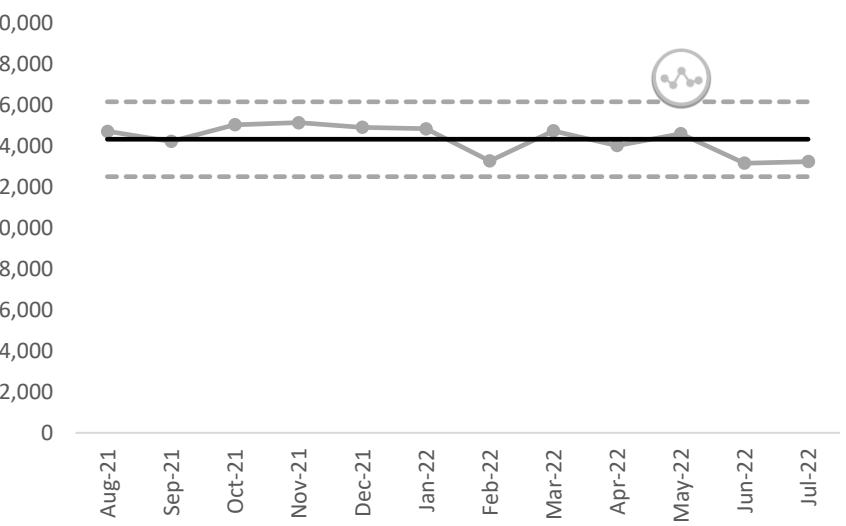
Delayed discharges: NWL Acute trust performance is close to the London Regional average. THH and LNW have the lowest LOS across all three measures whilst LOS at C&W and ICHT has stabilised or reduced.

Escalations by Theme:

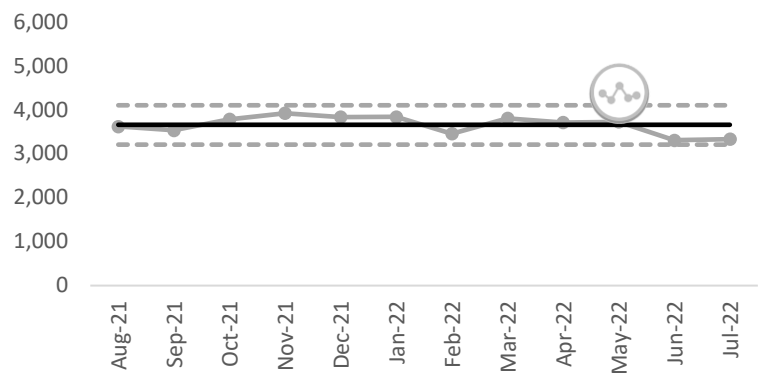
- LAS handover delays at NP
- Learning from C&W and WMUH on managing time in department

Metric: Ambulance Conveyances
CQC Domain: Responsive
Month: July 2022
Target: N/A

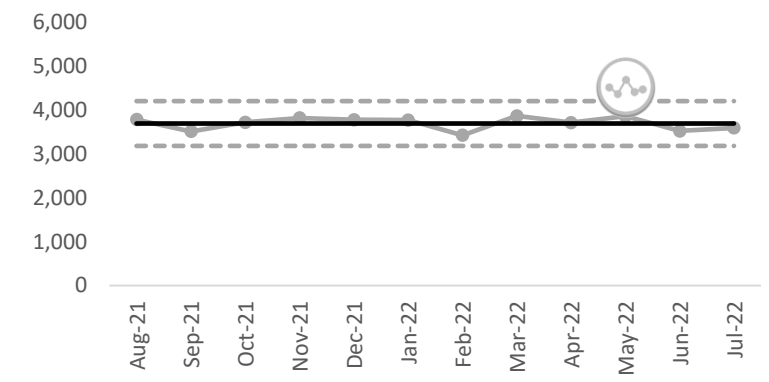
LAS Conveyances - Sector



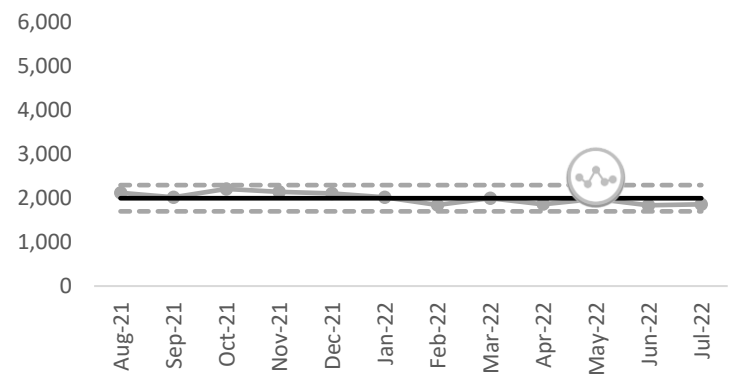
LAS Conveyances - CWH



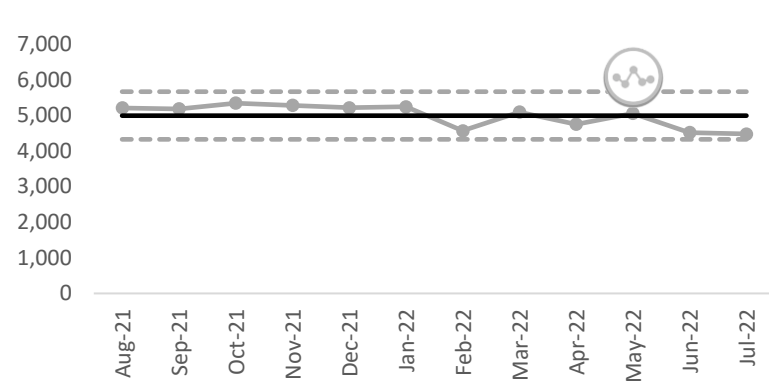
LAS Conveyances - ICH



LAS Conveyances - THH



LAS Conveyances - LNW



Ambulance Conveyances

Ambulance Conveyances

Acute Provider Collaborative Summary:

Ambulance conveyances has remained relatively stable over the last 12 months.

Trust highlights:

LNW: Northwick Park Hospital continues to receive the highest number of ambulances over any other hospital site in London.

Acute Provider Collaborative Actions:

Trust actions:

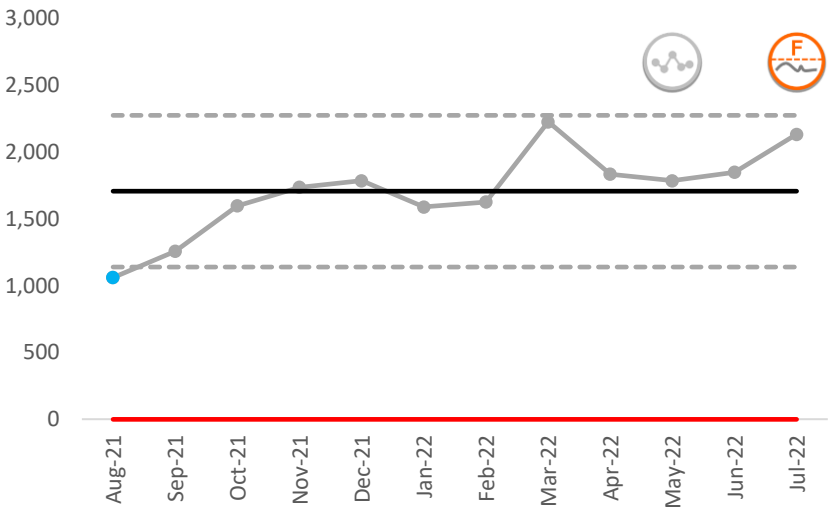
LNW: Continued discussions with LAS re direction to Ealing and wider. Further focus with LAS regarding out of area conveyances. Continue RAT Team approach at NPH and strengthening process at Ealing

Acute Provider Collaborative Assurance & Timescales for improvement

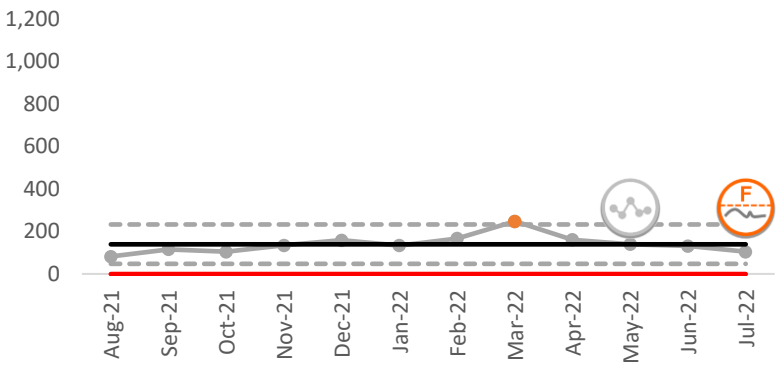
Monitored through the local executive and assurance groups and the UEC Board.

Metric: LAS patient handover 30 min breaches
CQC Domain: Responsive
Month: July 2022
Target: tbc

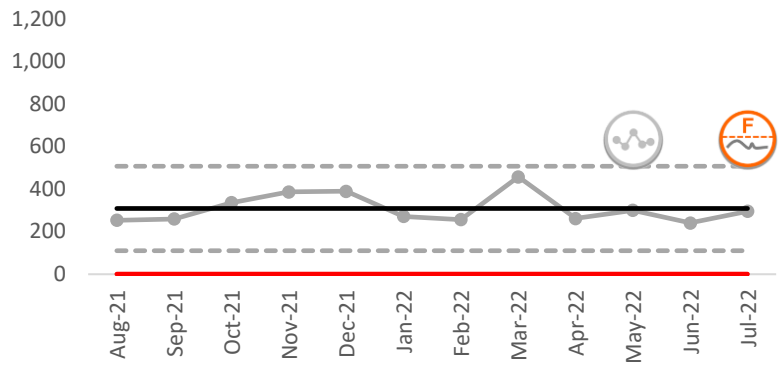
LAS patient handover 30 min Breaches - Sector



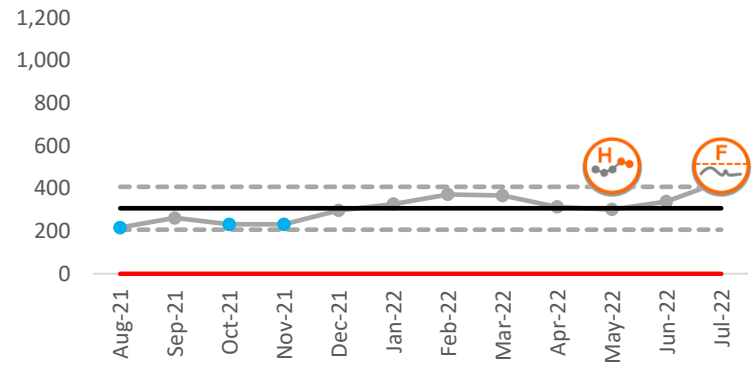
LAS patient handover 30 min Breaches - CWH



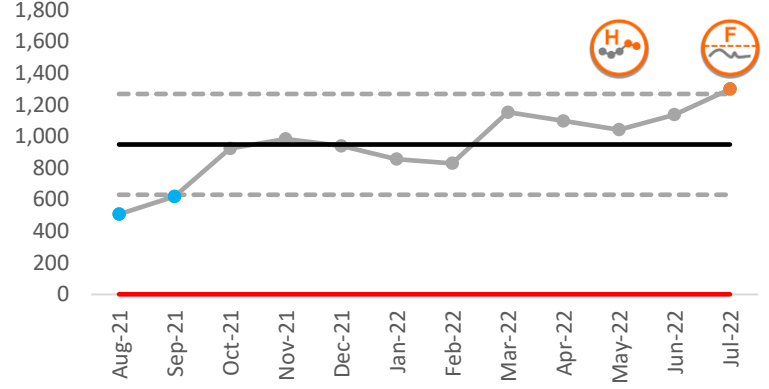
LAS patient handover 30 min Breaches - ICH



LAS patient handover 30 min Breaches - THH



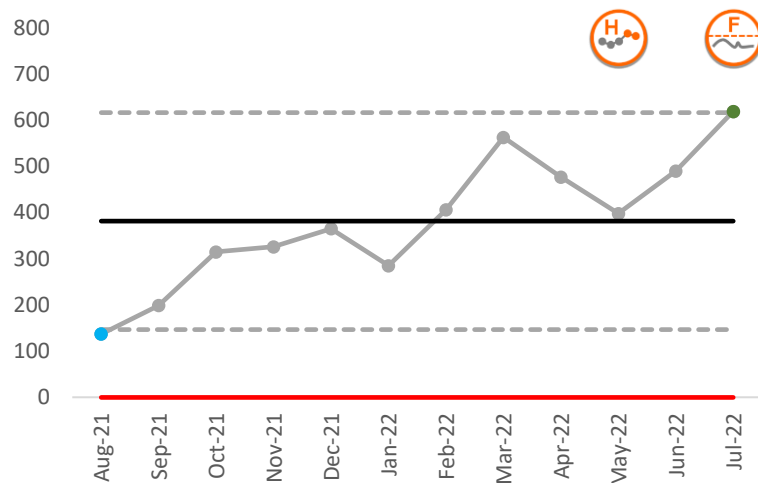
LAS patient handover 30 min Breaches - LNW



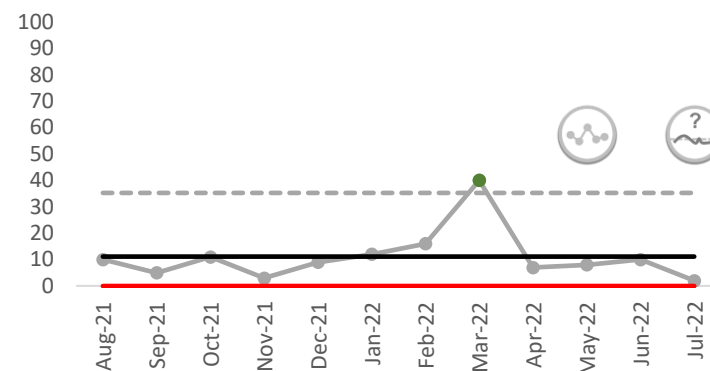
LAS patient handover 30 min breaches

Metric: LAS patient handover 60 min breaches
CQC Domain: Responsive
Month: July 2022
Target: tbc

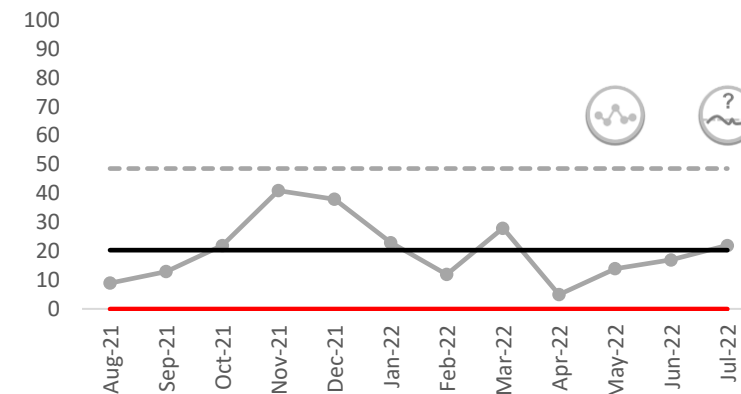
LAS patient handover 60 min Breaches - Sector



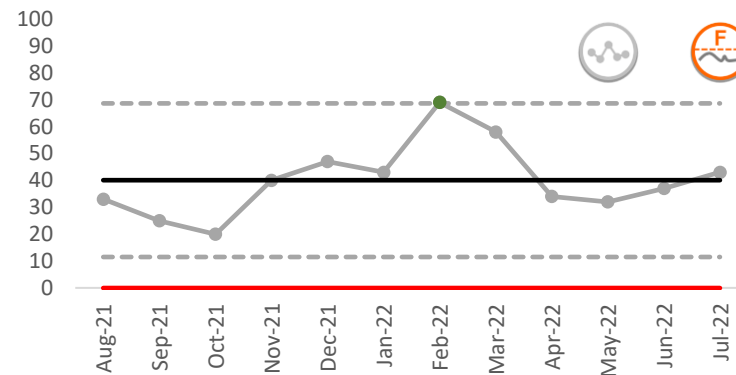
LAS patient handover 60 min Breaches - CWH



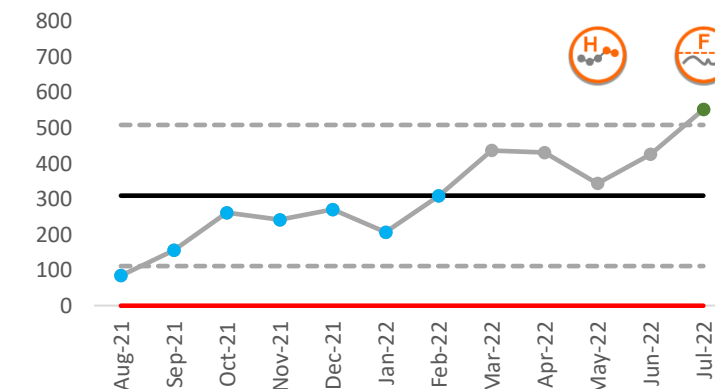
LAS patient handover 60 min Breaches - ICH



LAS patient handover 60 min Breaches - THH



LAS patient handover 60 min Breaches - LNWH



LAS patient handover 60 min breaches

LAS patient handover 30 & 60 min breaches

Acute Provider Collaborative Summary:

LAS 30 and 60 minute handover breaches are an issue at LNW and rising.

Trust highlights:

CWFT: The Trust saw an improvement in ambulance handover times for both 30 and 60 minute metric and remains amongst the top performing in London on these metrics.

ICHT: Overall, the Trust hospital ambulance handover times continue to benchmark well across the London sector.

THH: performance is affected by flow as no capacity to cohort patients in the department

LNW: Increasing volume of breaches. Requirement to assess as a percentage of conveyances received. Delays often caused by high volumes arriving at similar times, requiring continued step downs from resus. ED regularly impacted with significant number of cubicles blocked by long waiting mental health patients.

Acute Provider Collaborative Actions:

Trust actions:

CWFT:

ICHT: This continues to be a priority focus for the emergency department. Escalation strategy linked into the Trust's full capacity protocols to avoid 60 minute breaches (in progress).

THH: Actions to improve flow from ED to wards/discharge will help debulk the department allowing swift handover of LAS patients

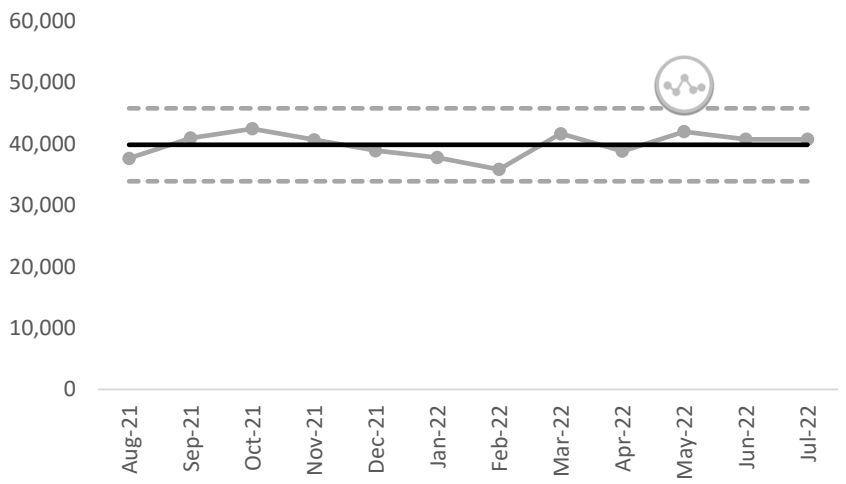
LNW: Continued discussions with LAS redirection to Ealing and wider. Further focus with LAS regarding out of area conveyances. Continue RAT Team approach at NPH and strengthening process at Ealing. Improved response for mental health decompression.

Acute Provider Collaborative Assurance & Timescales for improvement

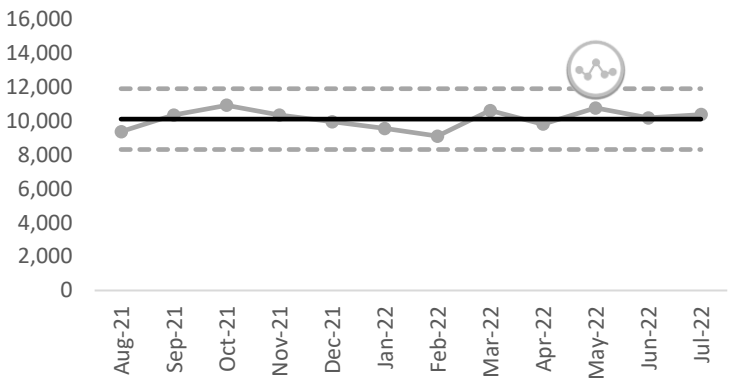
Monitored through the local executive and assurance groups and the UEC Board.

Metric: A&E ED Attendances(Type 1 only)
CQC Domain: Responsive
Month: July 2022
Target: N/A

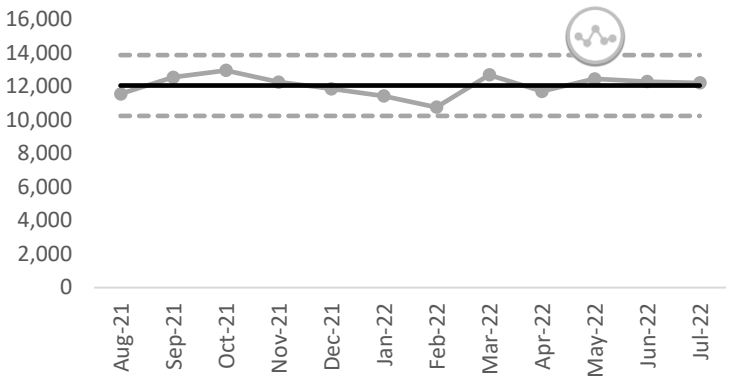
A&E ED Attendances - Sector



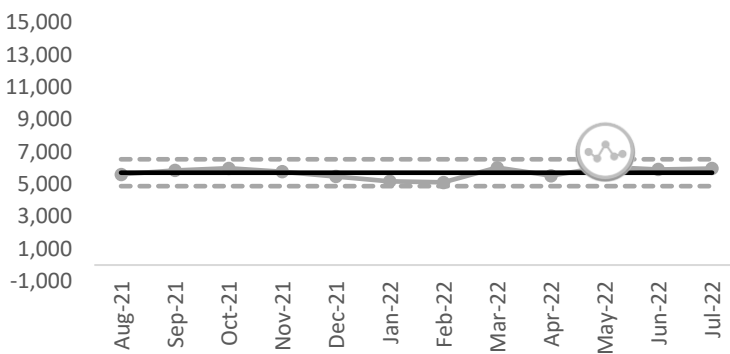
A&E ED Attendances - CWH



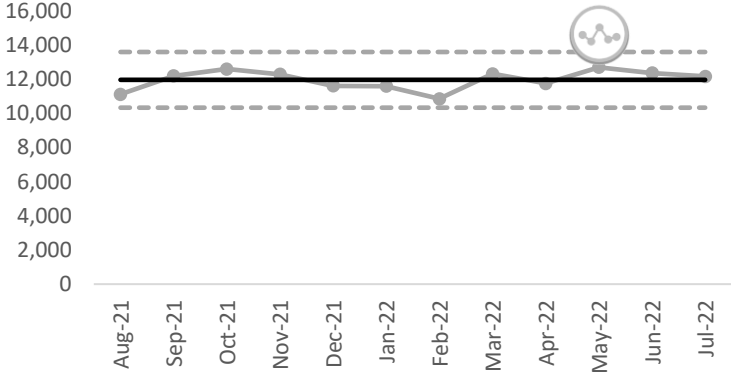
A&E ED Attendances - ICH



A&E ED Attendances - THH



A&E ED Attendances - LNW



A&E ED Attendances (Type 1 only)

A&E ED Attendances (Type 1 only)

Acute Provider Collaborative Summary:

No significant concerns. Activity has remained relatively stable over the last 12 months

Acute Provider Collaborative Actions:

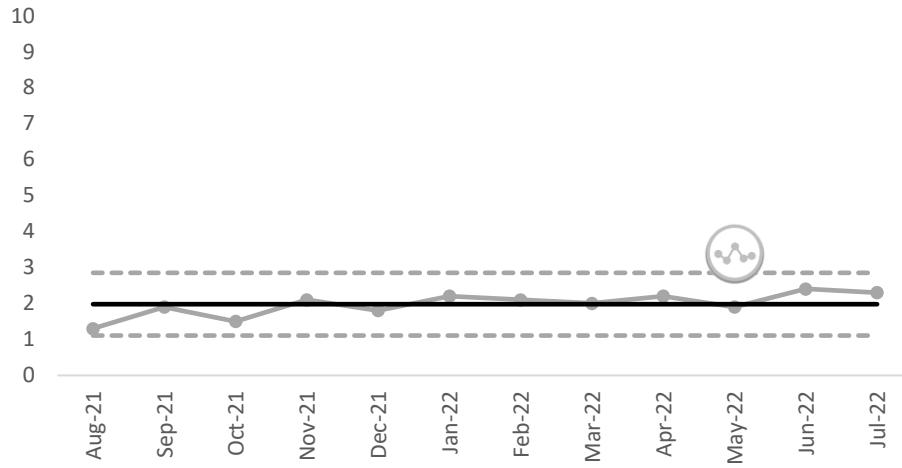
Acute Provider Collaborative Assurance & Timescales for improvement

- Monitored through the local executive and assurance groups and the UEC Board.

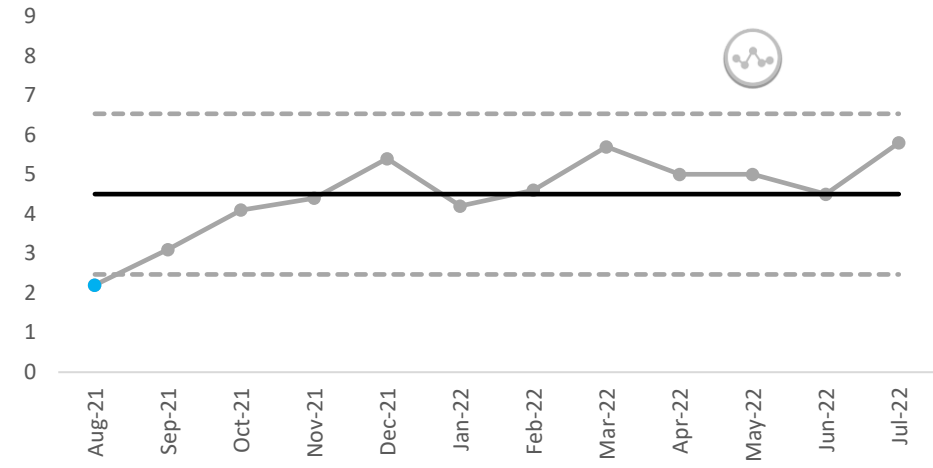
Metric: A&E % Spending >12hrs in department
CQC Domain: Responsive
Month: July 2022
Target: zero

A&E % Spending >12hrs in department

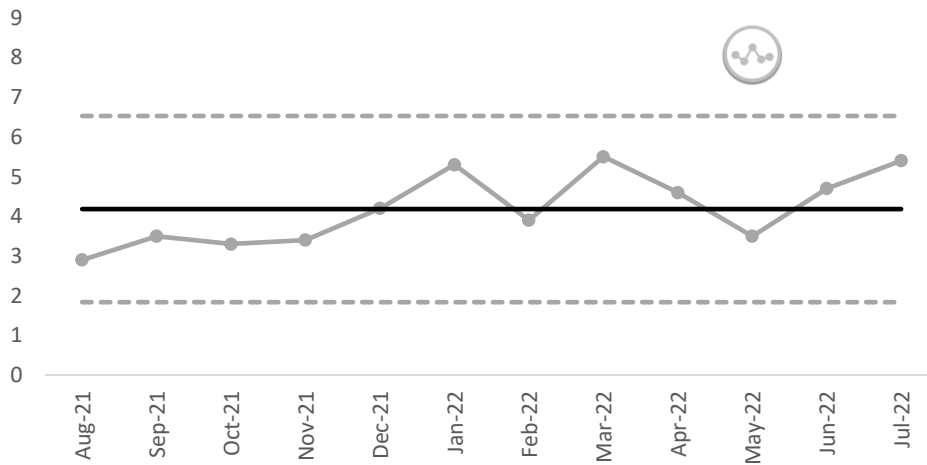
A&E - % Spending >12 hours in Department - CWH



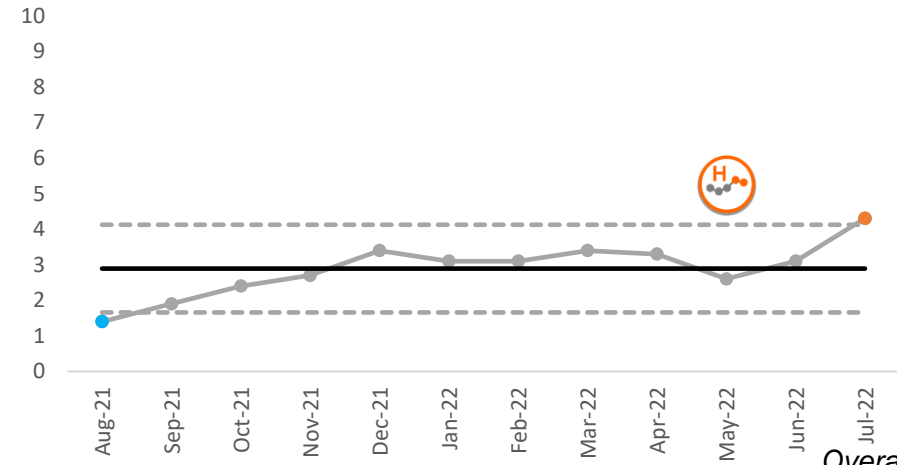
A&E - % Spending >12 hours in Department - ICH



A&E - % Spending >12 hours in Department - THH



A&E - % Spending >12 hours in Department - LNWH



A&E % Spending >12hrs in department

Acute Provider Collaborative Summary:

This metric was introduced during 2021-22 and is regarded as a better measure of safe and effective care. The % of patients spending more than 12 hours in A&E should be as low as possible.

Average waits are between 1-5%, with performance at C&W and WMUH consistently at the lower end. Further work should be undertaken to adopt any learning from C&WFT

Acute Provider Collaborative Actions:

Trust actions:

CWFT: performing well

ICHT: Priority areas for autumn are the drive to improve ward routines and board rounds as part of a Trust-wide programme to improve earlier discharge times, focus on SDEC and Acute medical pathways to ensure fast moves out of ED, and focus on triggers, actions and communication as part of daily site routines. For mental health pathway delays, a separate assessment unit is expected to be open by December 2022 (this formed part of the 2022/23 is part of the ICHT capital plan).

THH: Time to first clinician, focus on ED to SDEC and AMU & Frailty pathways to reduce the amount of time patients spend in ED. MH patients a particular challenge, working with CNWL to create a MH Lounge in the hospital to aid this.

LNW: Improved response for mental health decompression. Additional internal winter beds planned. Additional focus on discharge productivity including mitigating loss of DTA funding.

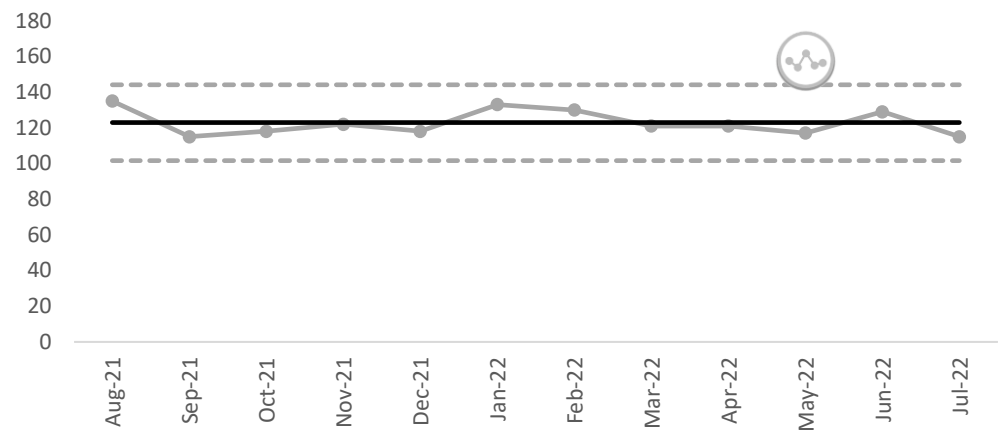
Acute Provider Collaborative Assurance & Timescales for improvement

Monitored through the local executive and assurance groups and the UEC Board.

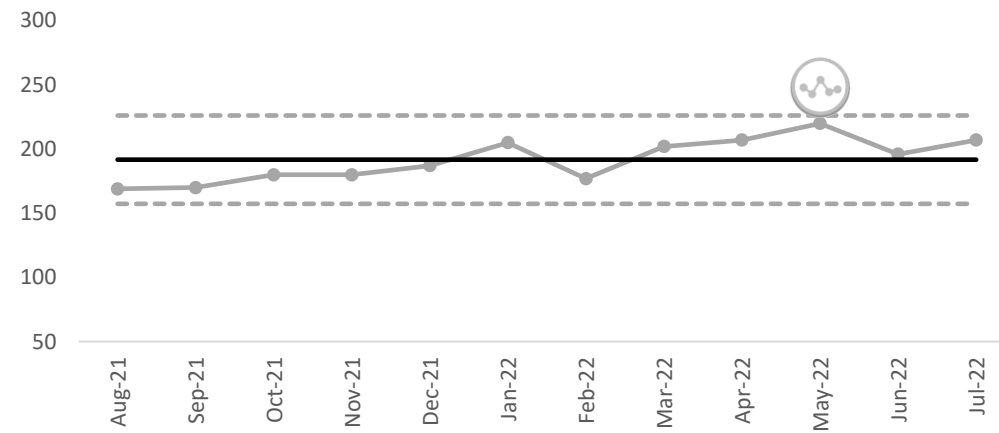
Metric: Non-elective patients >21 day stay
CQC Domain: Effective
Month: July 2022
Target: tba

Non-elective patients >21 day stay

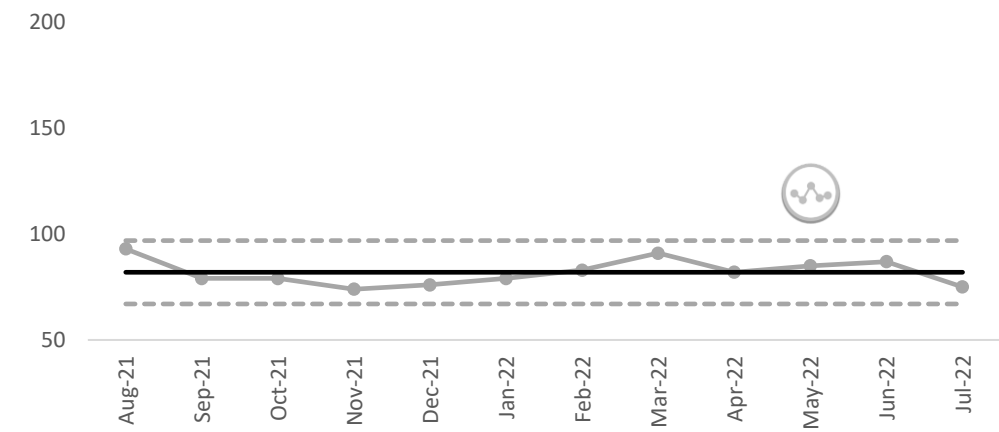
Non Elective Patients >21 day stay - CWH



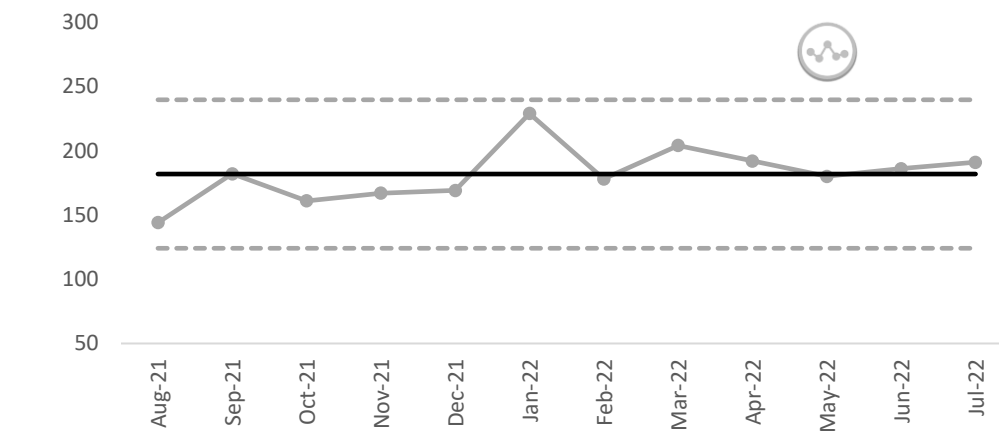
Non Elective Patients >21 day stay - ICH



Non Elective Patients >21 day stay - THH



Non Elective Patients >21 day stay - LNWH



Non-elective patients >21 day stay

Acute Provider Collaborative Summary:

The focus is on continued partnership as an ICS on quality of pathway referrals and speed of response. The data presented provides absolute numbers which is important at trust level in relation to bed base, but further work is required to agree the most relevant metric(s) relating to discharge delays.

Acute Provider Collaborative Actions:

APC: all trusts have adopted the national best practice pathways (being led by Lesley Watts)

Acute Provider Collaborative Assurance & Timescales for improvement

- Monitored through the local executive and assurance groups and the UEC Board and as part of national/regional dashboard.

Cancer Care Summary

Executive Summary:

The four acute trusts in NWL are members of RM Partners, the West London Cancer Alliance. RM Partner's strategy sets out the partners' ambition for cancer care in West London with a particular focus on returning care pathway performance to national expectations to improve patient outcomes.

Performance against the four key metrics is closely monitored at trust level and through RM Partners with funding being allocated to support targeted improvement projects. More detail by specialty area is provided in Appendix 4.

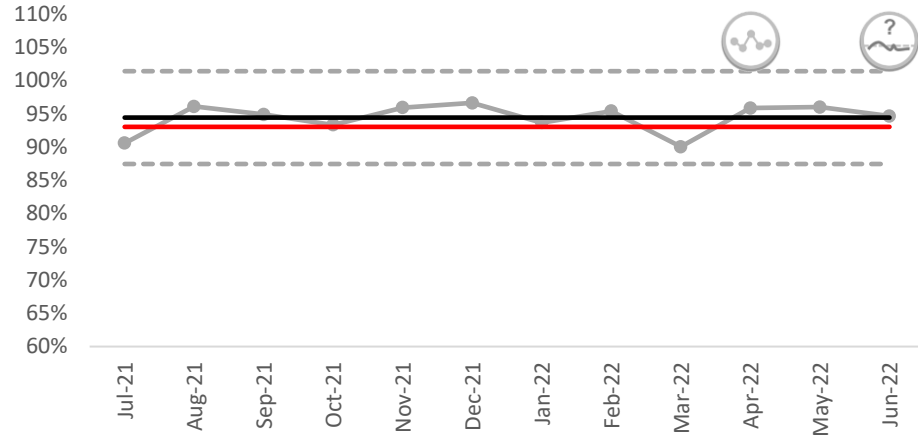
Escalations by Theme:

- 62 day GP to first treatment

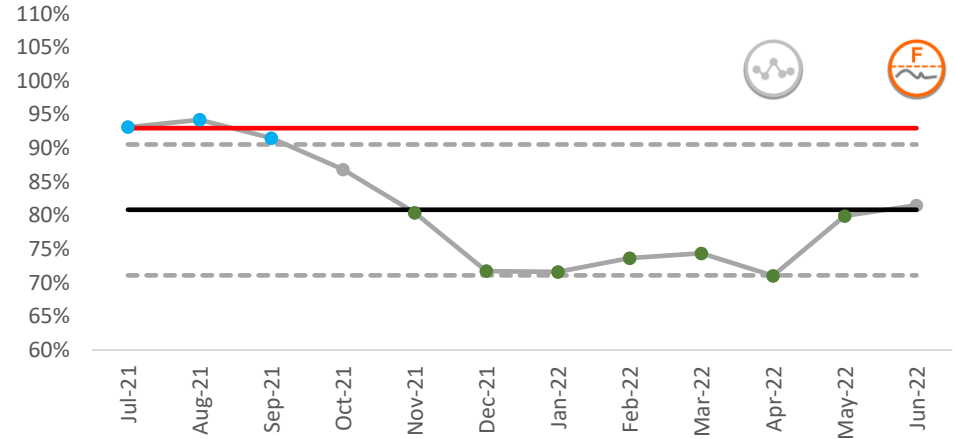
Metric: 2ww referral to first OP
CQC Domain: Responsive
Month: July 2022
Target: >93%

2ww referral to first OP

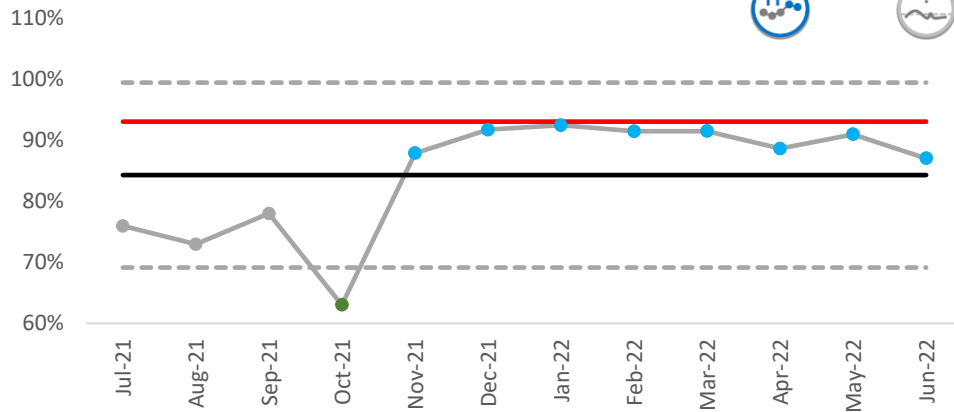
2 WW referral to first op - CWH



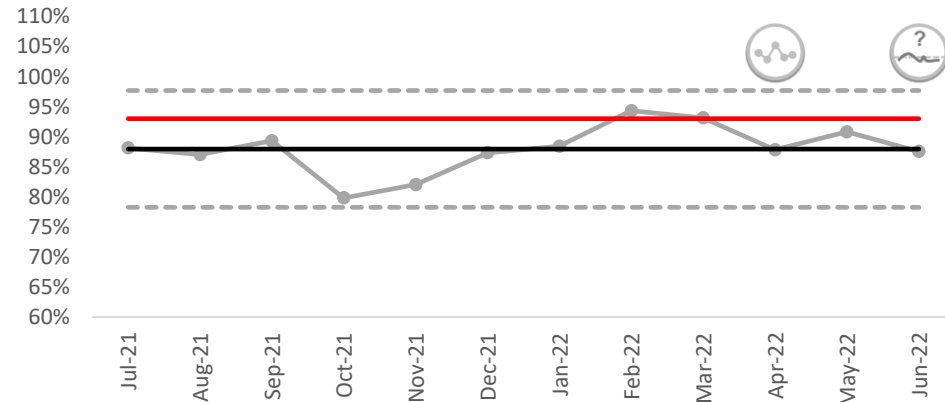
2 WW referral to first op - ICH



2 WW referral to first op - THH



2 WW referral to first op - LNWH



2ww referral to first OP

Acute Provider Collaborative Summary:

CWFT is the only trust consistently meeting this target, although all trusts have seen improvements to close to target over the last few months.

Trust highlights:

LNW: Continued increase in 2WW weekly activity compared to 19/20 baseline placing pressure on 2WW performance. Baseline 534, current position 1,123, significantly higher compared to rest of sector

THH: Trust has seen a 115% increase in 2WW activity compared to pre-covid baselines

Acute Provider Collaborative Actions:

Trust actions:

CWFT: target being met

ICHT: Longstanding challenges in the breast service which have caused underperformance since October 2021 have been fully resolved. The Trust has initiated a cancer recovery board, chaired by the CEO, to oversee the delivery of all recovery objectives and improvement against all CWT measures. The first meeting was held on 17/08/2022 and comprises clinical service deep dives and core support service updates.

THH: creating additional capacity in 2WW clinics, one stop and straight to test diagnostic slots

LNW: Partnership support required across the sector to manage continued high demand.

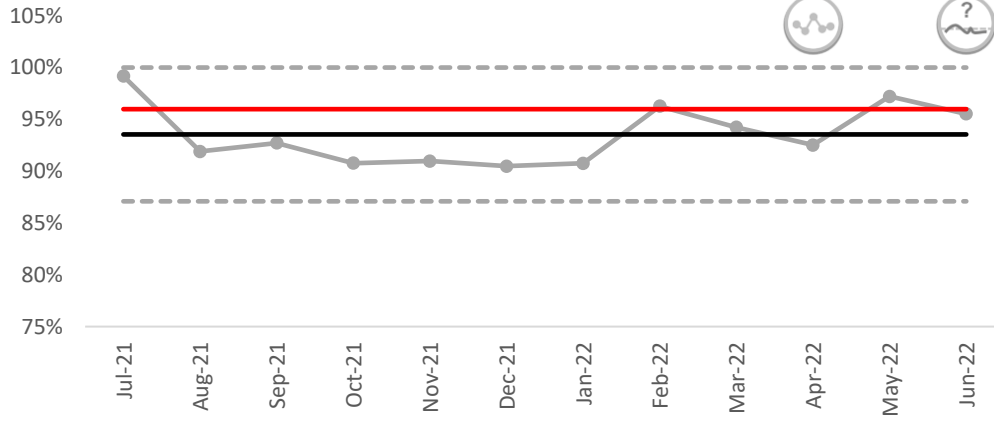
Acute Provider Collaborative Assurance & Timescales for improvement

- Monitored through the local executive and assurance groups and via RM Partners West London Cancer Alliance

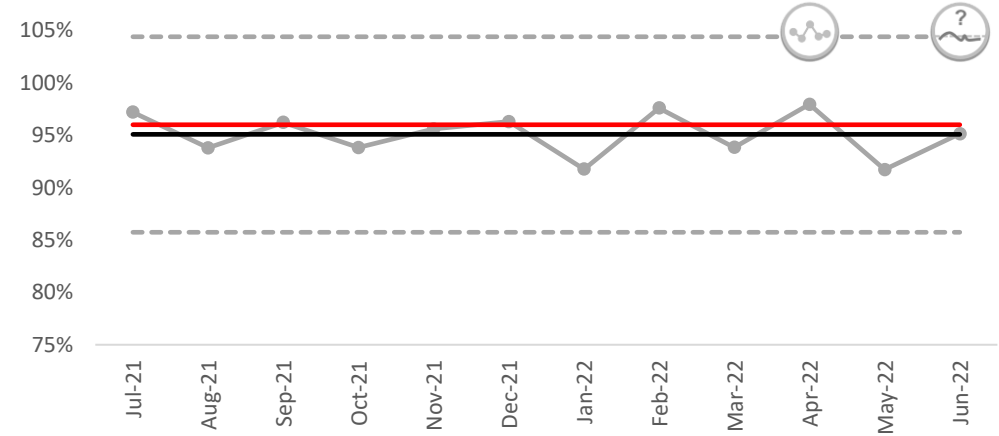
Metric: 31 day diagnosis
CQC Domain: Responsive
Month: July 2022
Target: >96%

31 day diagnosis

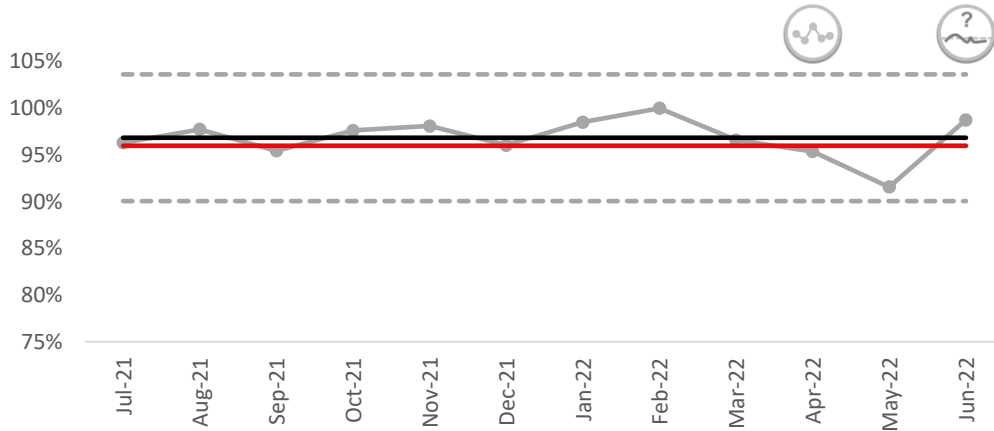
31 days diagnosis - CWH



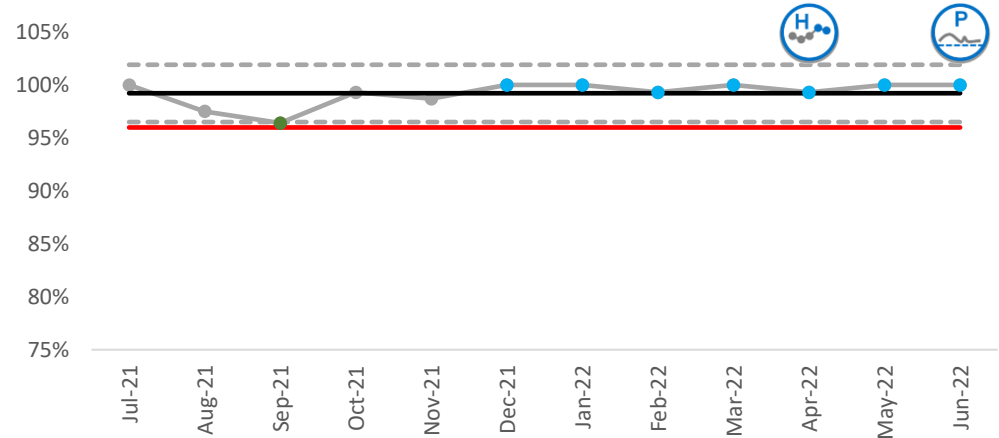
31 days diagnosis - ICH



31 days diagnosis - THH



31 days diagnosis - LNWH



31 day diagnosis

Acute Provider Collaborative Summary:

All trusts are achieving this standard.

Trust highlights:

CWFT: Occasional non compliance is driven by the colorectal pathway as well as clinically complex patients undergoing surgery following extensive pre-operative work.

Acute Provider Collaborative Actions:

Trust actions:

ICHT: Longstanding challenges in the breast service which have caused underperformance since October 2021 have been fully resolved

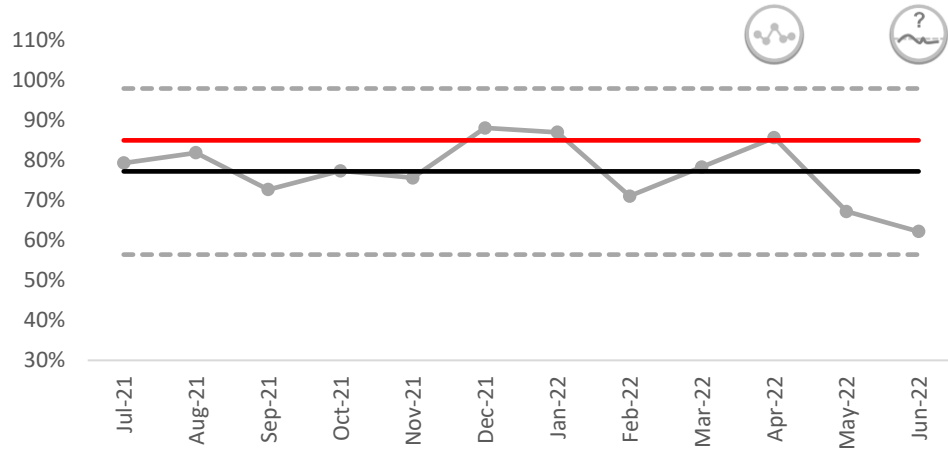
Acute Provider Collaborative Assurance & Timescales for improvement

- Monitored through the local executive and assurance groups and via RM Partners West London Cancer Alliance

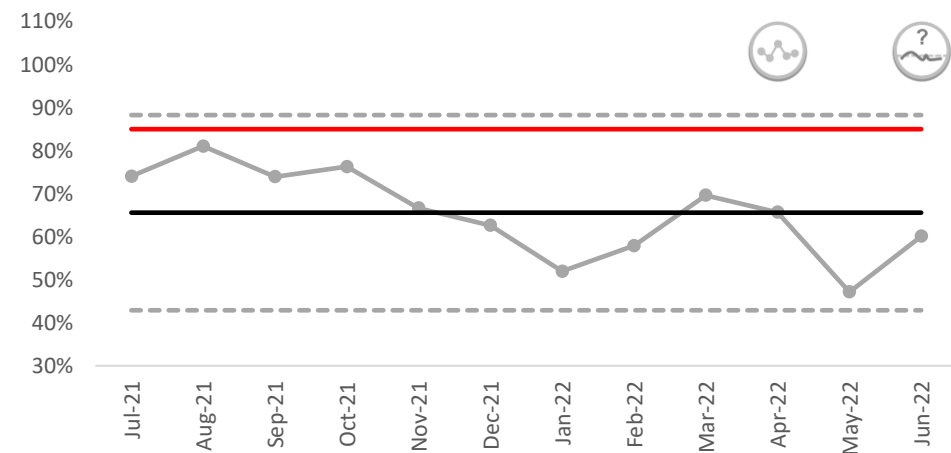
Metric: 62 day GP to first treatment
CQC Domain: Responsive
Month: July 2022
Target: >85%

62 day GP to first treatment

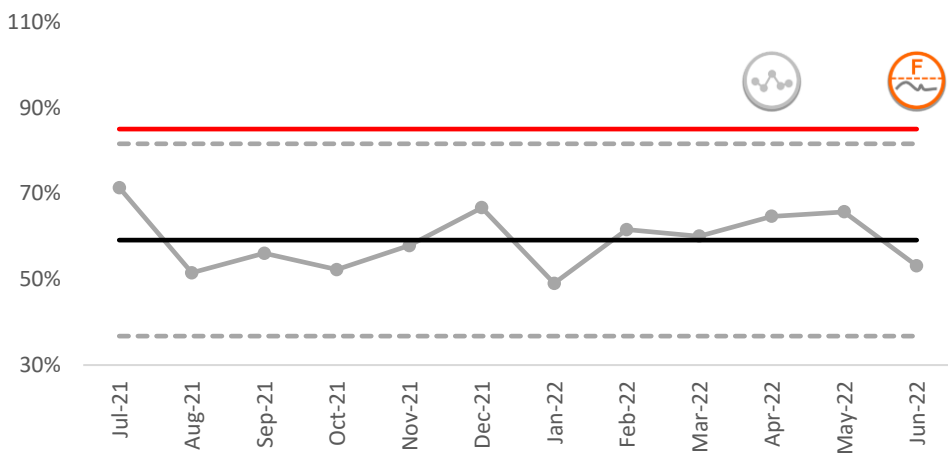
62 days GP to first treatment - CWH



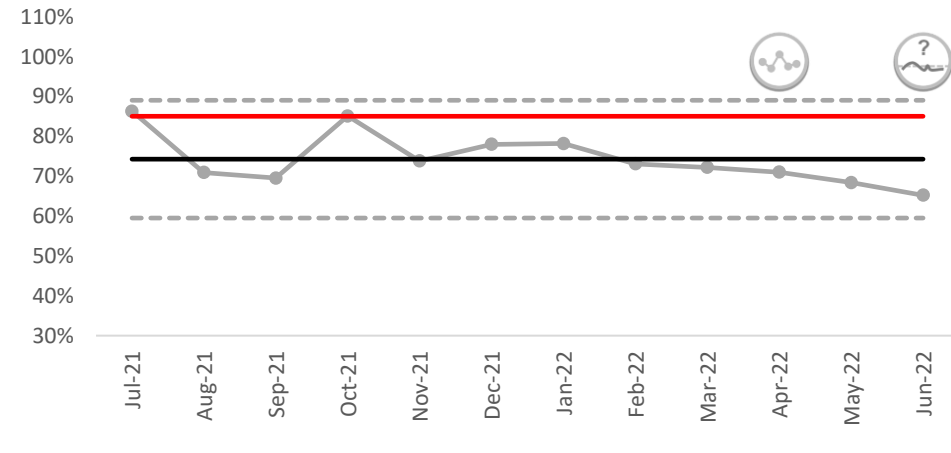
62 days GP to first treatment - ICH



62 days GP to first treatment - THH



62 days GP to first treatment - LNWH



62 day GP to first treatment

Acute Provider Collaborative Summary:

No trust is hitting this standard consistently and there is some early evidence of a trend toward deteriorating performance across two of the trusts.

Histopathology delays at NWL Pathlogy have been a contributor to delays in the pathway, but are now improving following a move to 6 day working.

Acute Provider Collaborative Actions:

Trust actions:

CWFT: tight management of pathways

ICHT: RMP has proposed additional intervention into GI pathways to improve 62-day PTL and CWT performance

THH: Streamline timed pathways to tighten up performance. Review urology to create RAPIDS prostate pathways & introduce bladder pathway. Daily escalation of pathology delays. Daily validation. Chase external diagnostics. Automated report being developed for radiology to aid 62 day and FDS performance.

LNW: Continue to recover the 62 day waiting list back log impacted by the Covid-19 pandemic. Improved timed pathways across the sector to reduce delays for inter trust transfers.

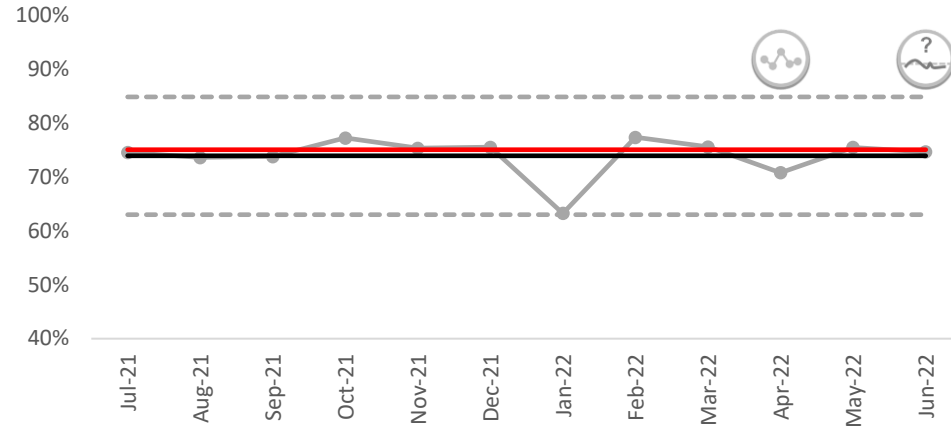
Acute Provider Collaborative Assurance & Timescales for improvement

Monitored through the local executive and assurance groups and via RM Partners West London Cancer Alliance

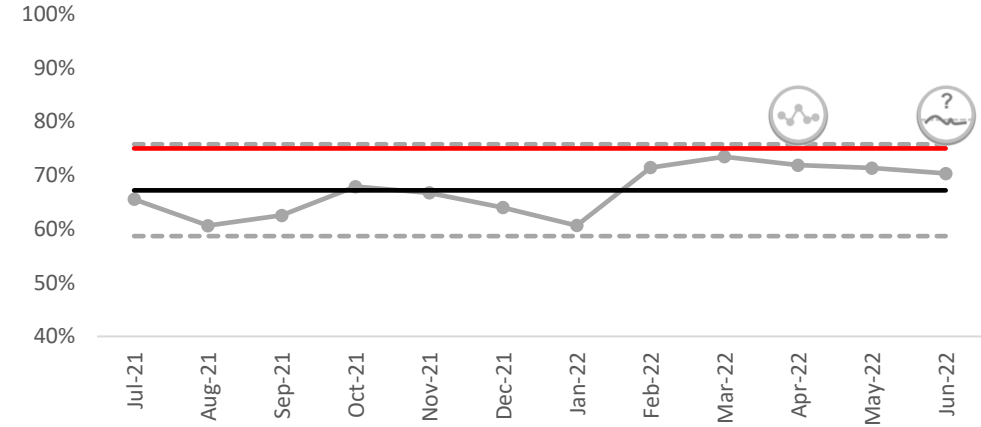
Metric: Cancer FDS
CQC Domain: Responsive
Month: July 2022
Target: >75%

Cancer Faster Diagnosis Standard (FDS)

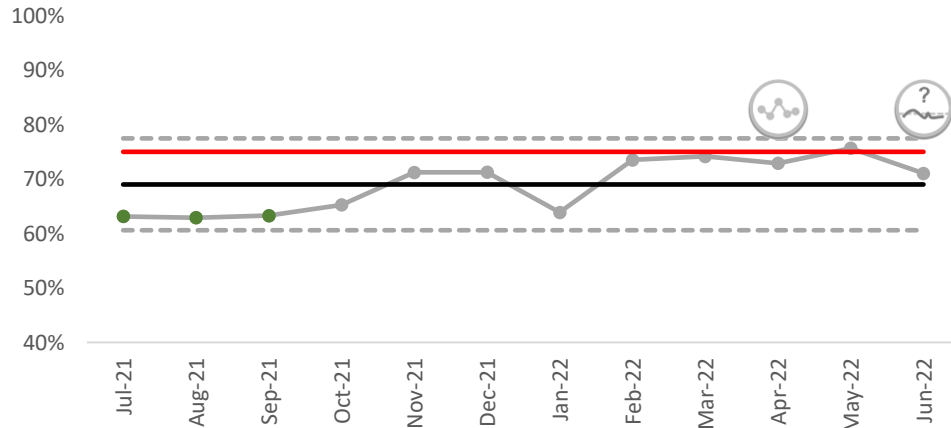
Cancer FDS - CWH



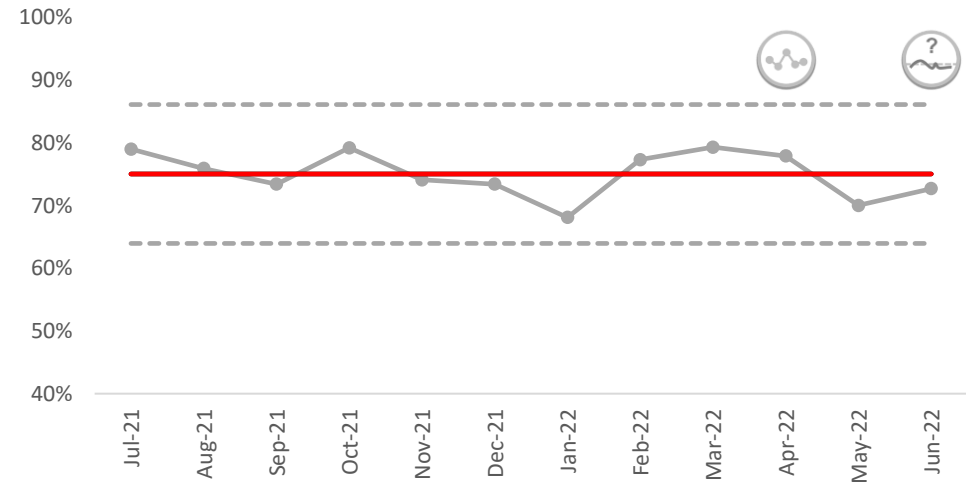
Cancer FDS - ICH



Cancer FDS - THH



Cancer FDS - LNWH



Cancer Faster Diagnosis Standard (FDS)

Acute Provider Collaborative Summary:

Performance has improved over the last 6 months, but further work required to ensure any improvement is sustainable.

Trust highlights:

CWFT: Underperformance has been due to pathway challenges across a number of key specialities.

LNW: Continued increase in 2WW weekly activity compared to 19/20 baseline placing pressure on the diagnostic pathway despite strong performance.

Acute Provider Collaborative Actions:

Trust actions:

CWFT: tight management of pathways

ICHT: FDS improvement meetings are in place with all key services, including detailed action plans at pathway level. An FDS deep dive report is published weekly. Following several months of focused improvement work, the Trust met the faster diagnosis standard for the first time in July 2022, three months ahead of schedule. Compliant performance is expected by October 2022.

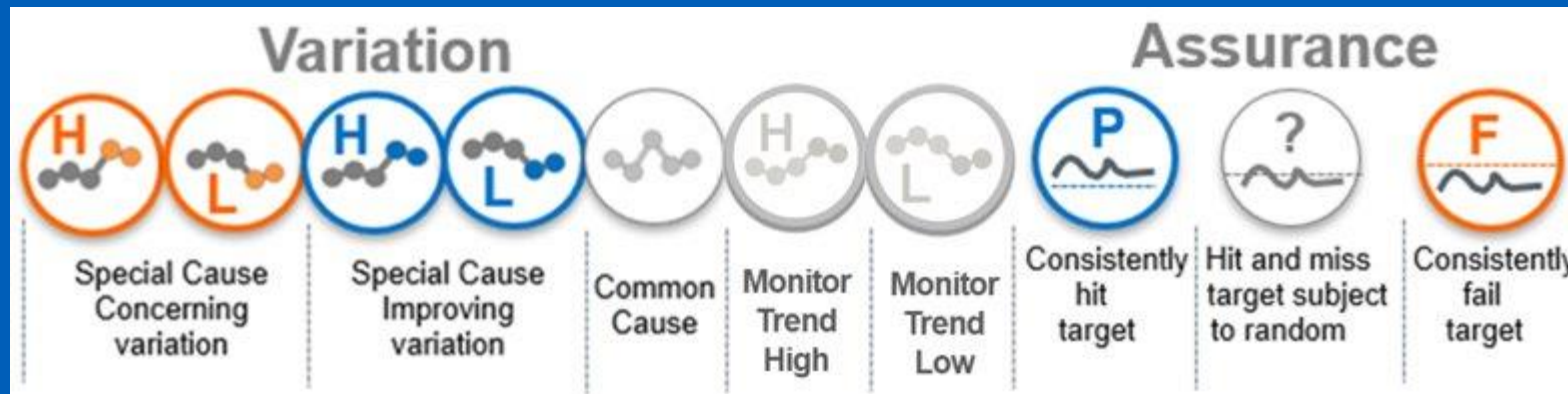
THH: Close work with 4 timed pathways and strengthen front end of diagnostic pathway. Automated report being developed for radiology to aid 62 day and FDS performance.

LNW: Embedding the Cancer Faster Diagnosis Champion to improve timed pathways across priority specialties.

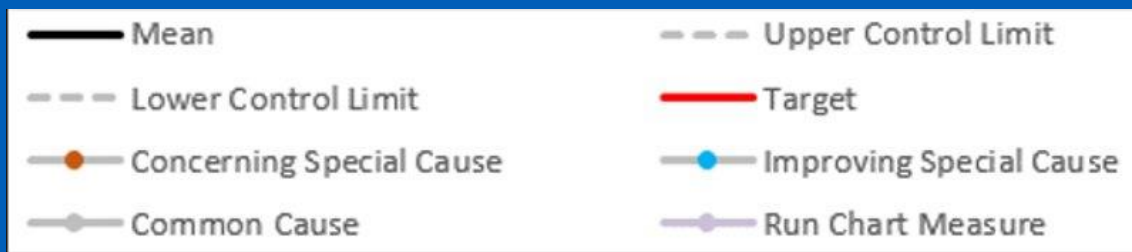
Acute Provider Collaborative Assurance & Timescales for improvement

- Monitored through the local executive and assurance groups and via RM Partners West London Cancer Alliance

Notes: SPC charts - Key



Further information on Making Data Count
<https://www.england.nhs.uk/publication/making-data-count/>



NW London Elective Care Programme Overview

SRO – Rob Hodgkiss

AD for Surgical Hubs – Victoria Medhurst

AD for Elective Care – Stephanie Good



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

Headlines

NWL delivery confidence is medium. Strong 78ww removal rate, elective activity, and OP 1st, across the sector.

Most recent data available as of 28/08/2022

Area	Metric	Current Performance (from 27/03/2022)	Plan	Confidence of delivery
P2s	P2 waiting list size	WE-28-08-2022 2,277	Maintain P2 waiting list size between 1,968 and 2,170 pts	Currently 1,982
	Number of 78ww	WE-28-08-2022 1,970 491	Remove 423 patients / wk	Current 78ww 413 Avg removals last 4 wks 1,285
Long Waiters	Number of 52ww	WE-28-08-2022 370 7,420	Reduce to 2,031 patients by March 2023	Current 52ww 7,420 Current week target 2,647
	Admitted PTL size	WE-28-08-2022 25,905	Reduction trajectory over the past 3 months	Currently 25,445 3 month growth -0.6%
Admitted	Elective Total Activity	WE-28-08-2022 24,787 122%	107% of BAU	4wk avg. 100% Current wk % 110% Pts seen this wk 5,199
	Non-Admitted PTL size	WE-28-08-2022 61% 221,473	Reduction trajectory over the past 3 months	Currently 221,473 3 month growth 8.5%
Non-Admitted	Outpatients First Activity	WE-03-07-2022 189,486 129%	107% of BAU	4wk avg. 108% Current wk % 124% Pts seen this wk 15,503
	Outpatients F/Up Activity	WE-28-08-2022 61% 135% 53%	> 75% of BAU	4wk avg. 89% Current wk % 106% Pts seen this wk 24,352

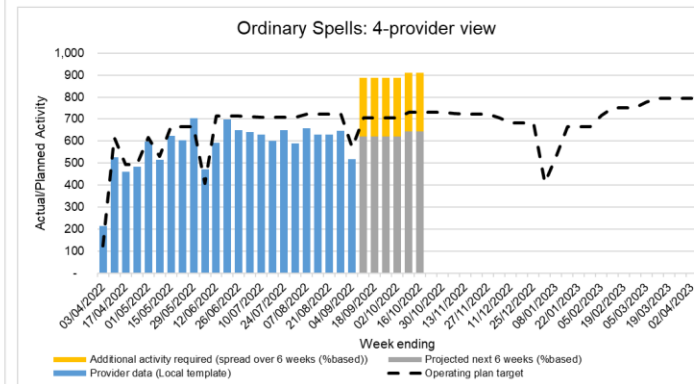
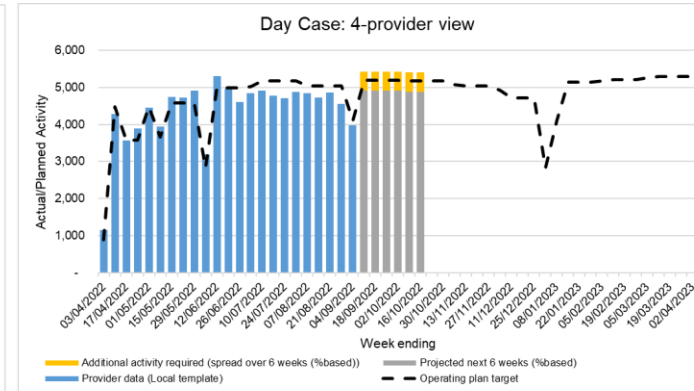
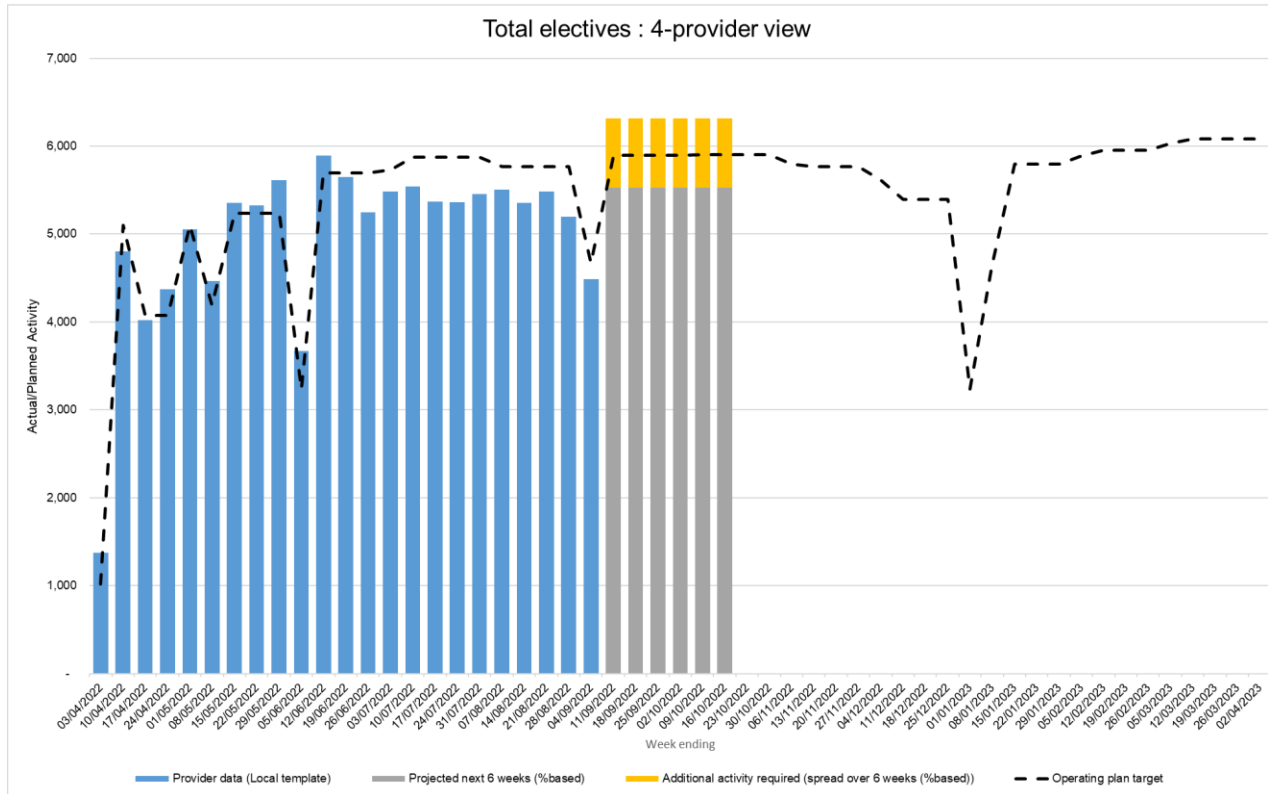
RAG rating key
 0% - 5%
 5% - 10%
 10% +



Sources: NHSL ICS RTT Tool & WAR monitoring report

Elective activity is currently averaging 93.67% of operating plan across the sector

- Best available indicative figures using the data provided by trusts on local template.



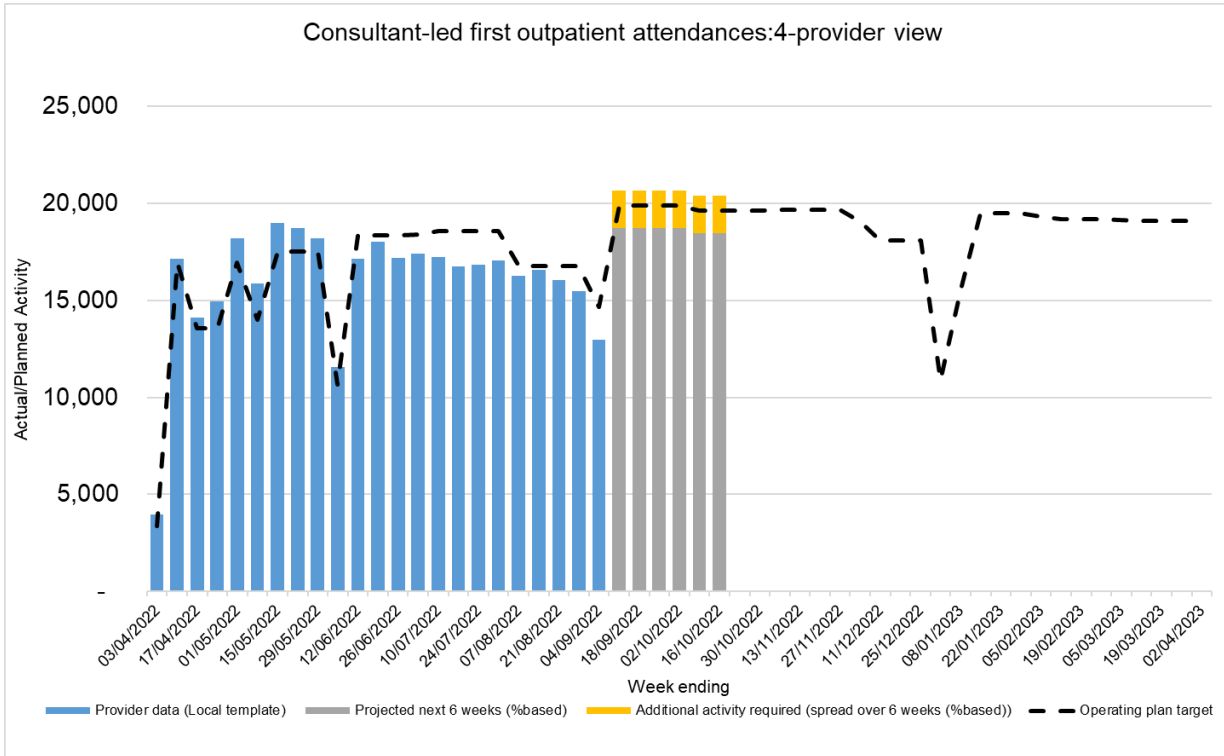
Assuming the activity will continue at 93.67% of Ops plan for the next 6 weeks:	
Total outstanding will be:	4,719
Outstanding per working day	157
Ordinary Spells	53
Day case	104

N.B. This report includes unvalidated operational data which needs to be viewed in conjunction with exception reports from trust teams.

Confidential information - not for further distribution

Source: Provider local template returns

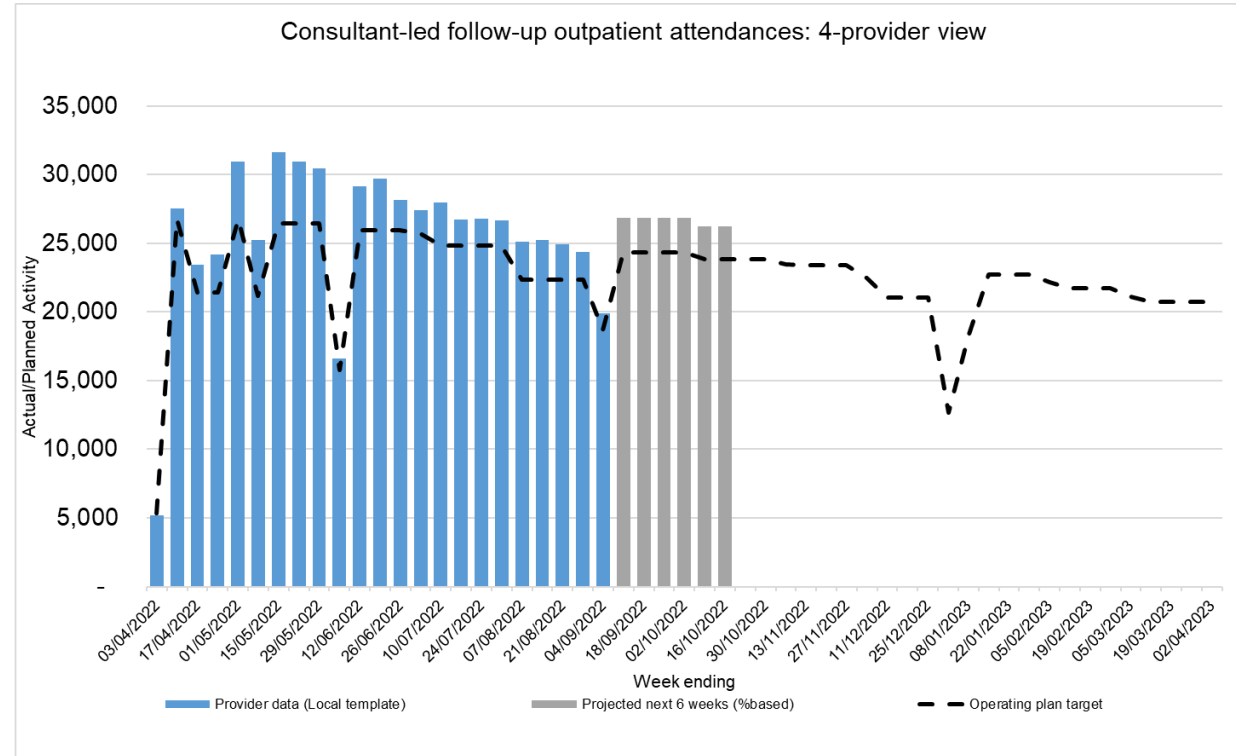
Outpatient first attendances currently average 94% of operating plan, with follow-ups continuing to run above plan



First appointments

Assuming the activity will continue at 94.03% of Ops plan for the next 6 weeks:

Total outstanding will be:	11,573
Outstanding per working day	386

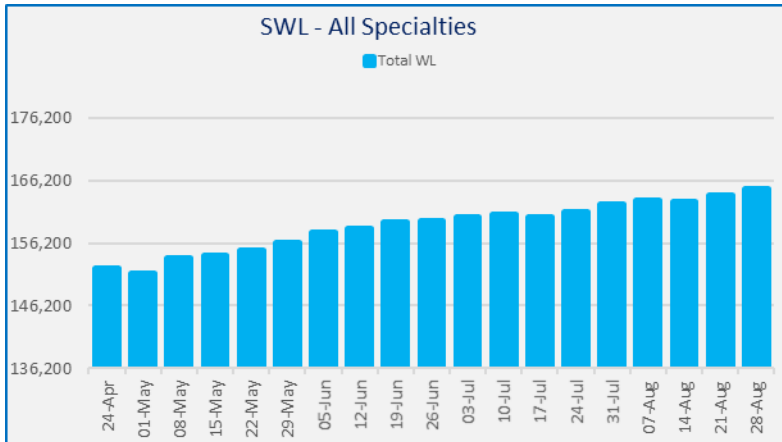
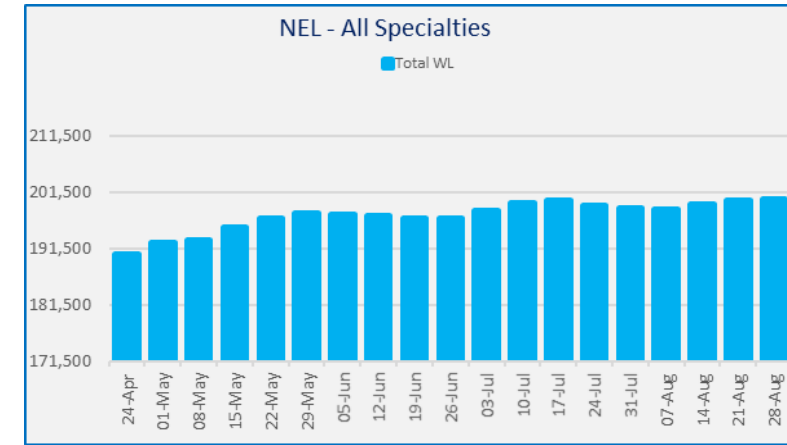
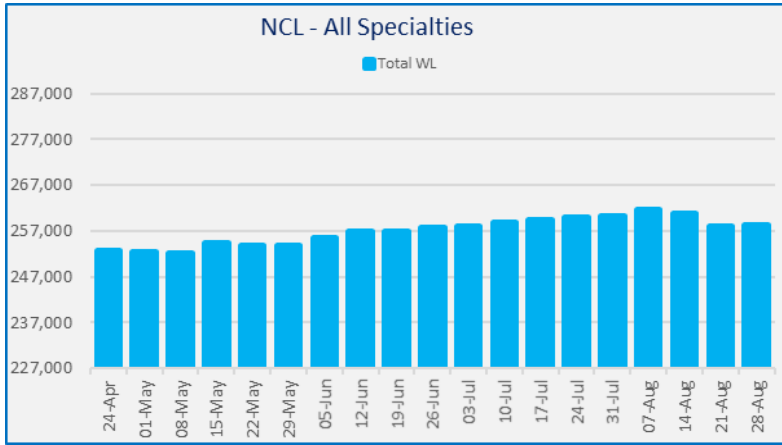


Follow-up appointments

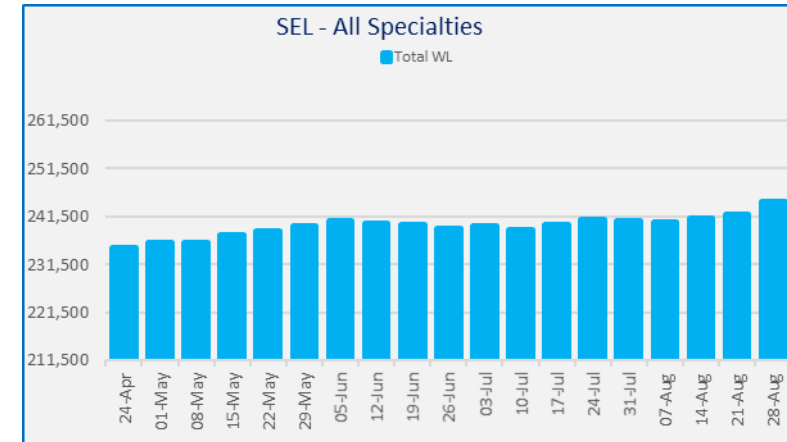
Assuming the activity will continue at 110.12% of Ops plan for the next 6 weeks:

In order to reduce activity to the required level we need to reduce the number of follow-up appointments by 448 per day

NWL has the second highest PTL in London, and last week the PTL grew by 0.6%.



Trust	PTL size	% change since last week
CWHFT	50,071	0.6%
ICHT	94,073	0.2%
LNWUHT	71,740	1.3%
THHFT	31,074	1.0%
NWL Total	246,958	0.7%



* To note: ICHT WLMDS submission issue for w/e 28/08 has been corrected locally in above figures

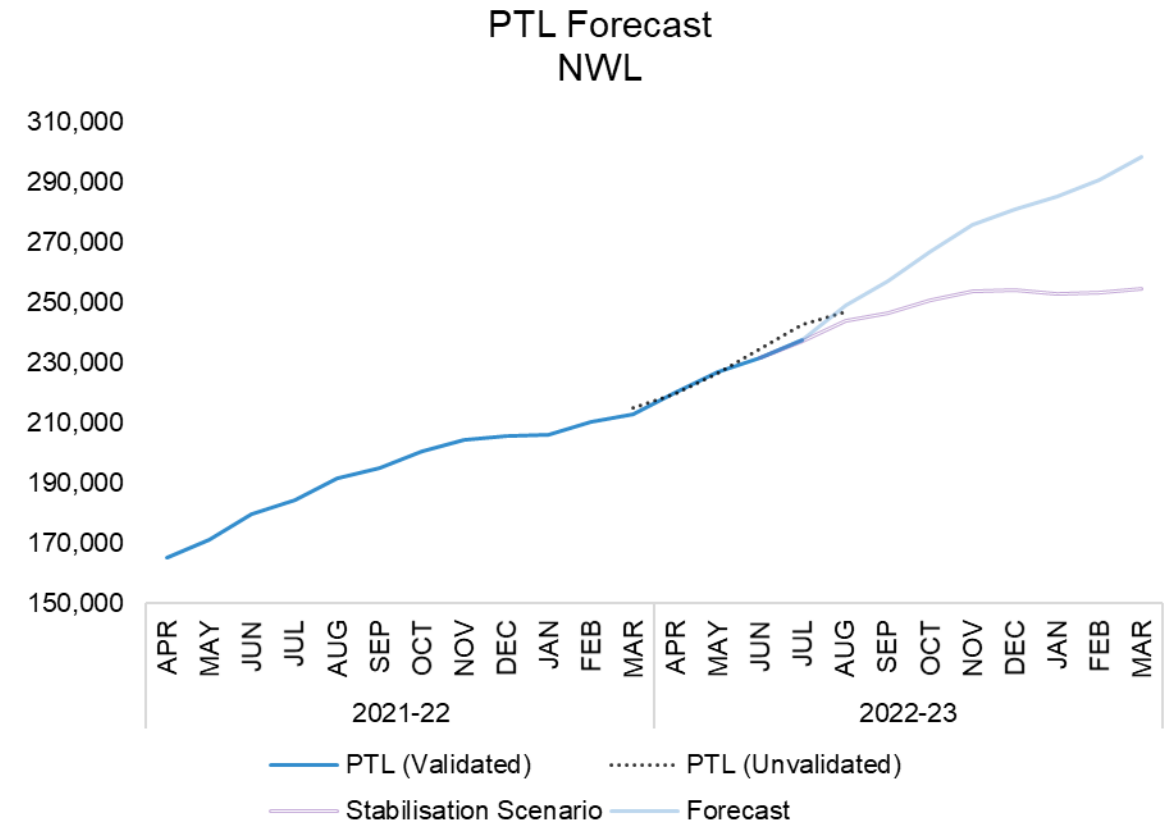
NWL PTL Forecast

Validated Jul-22 PTL is **246k**,
Growth of **16%** from Mar-22 (212k).

With current trends the PTL will reach **298k by Mar-22**.
Growth of **40%** from Mar-22.

If we improve clock stops by 12% over 21/22 levels in
H2 22/23 we can stabilise the PTL at **250k**.

Forecast	Metric	Mar-22 (validated)	Jul-22 (validated)	Aug-22 (unvalidated)	Mar-23 (Forecast)
NWL	PTL	212,772	237,660	246,791	298,121
	% Increase Over Mar-22	-	12%	16%	40%



The most significant proportion of PTL growth last week was accounted for by T&O, ENT and respiratory

The **PTL** grew by **1,540 (0.7%)** in 28/08/22.

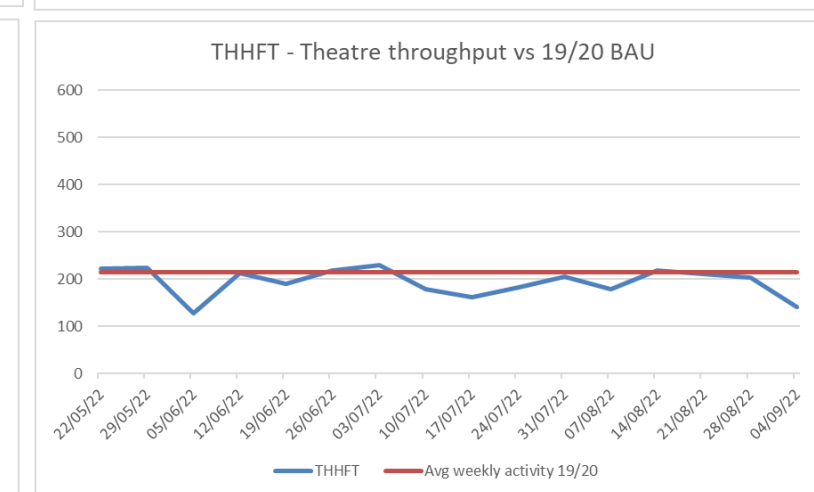
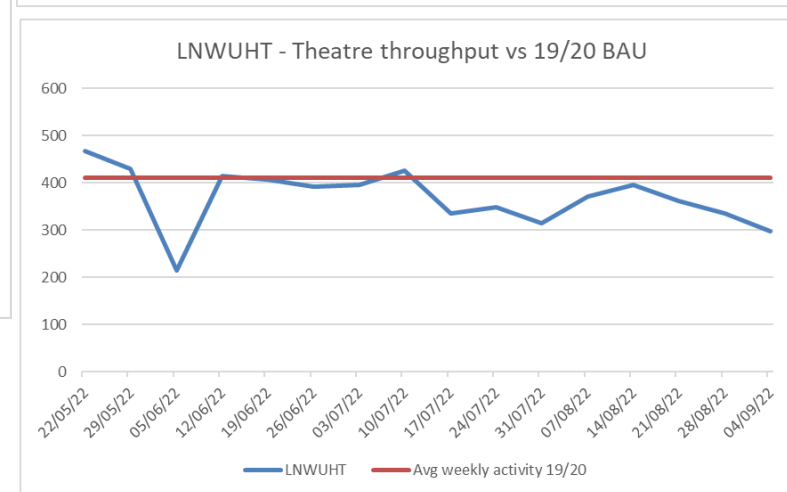
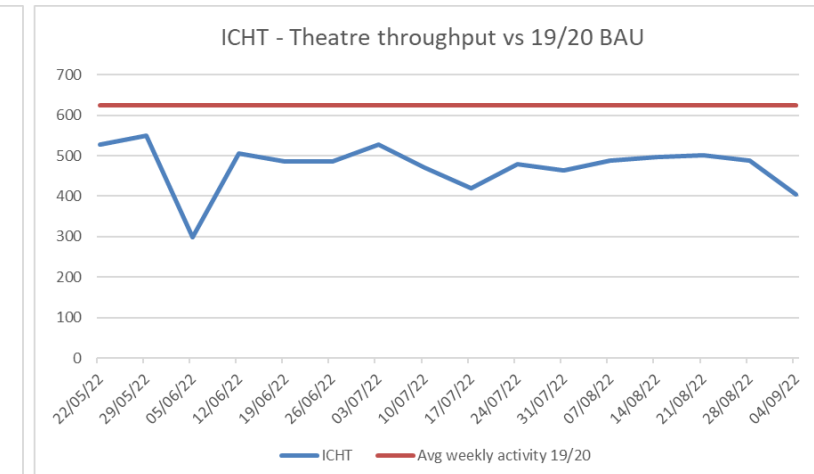
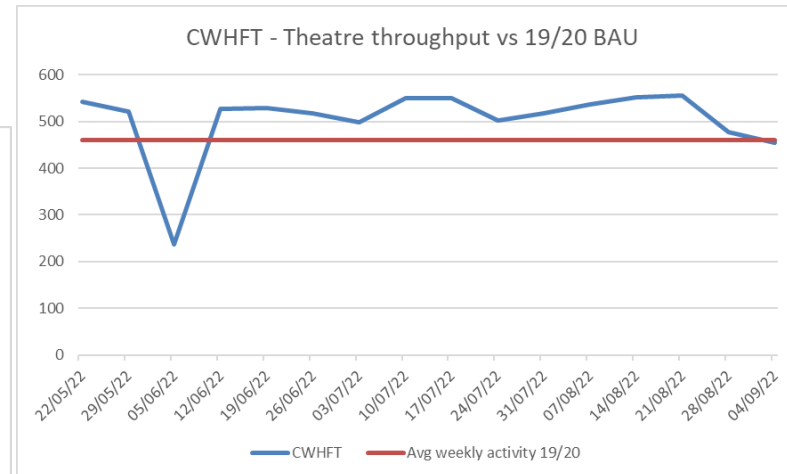
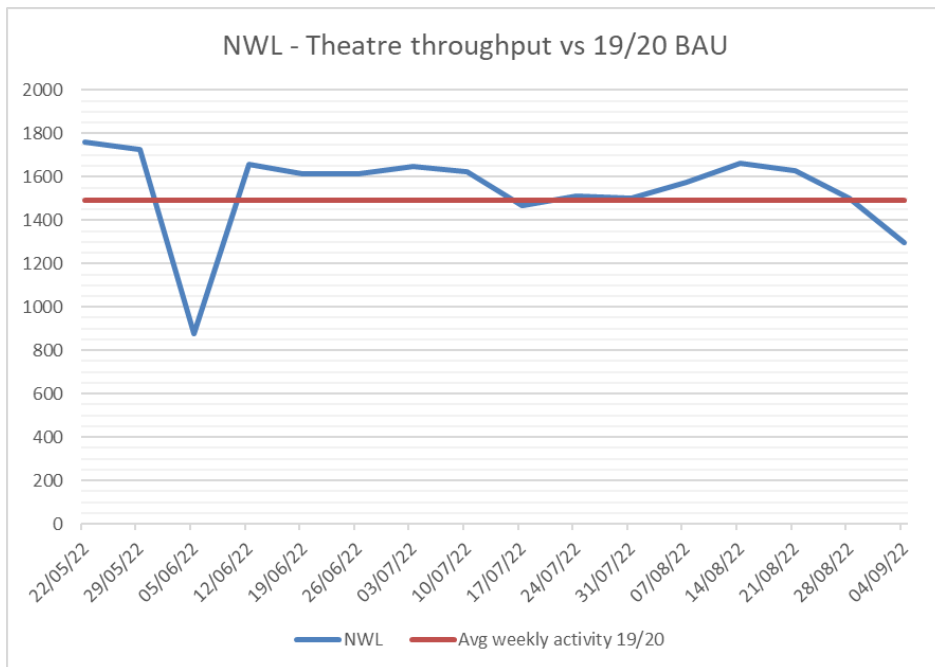
The below 6 specialties increased by 1,584 in total:

- T&O (307)
- ENT (294)
- Respiratory (291)
- Gastro (262)
- Dermatology (221)
- Colorectal (209)

PTL Change by Spec All Specialties	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	49,777	50,071	294	17.5%
ICHT	93,922	94,073	151	9.0%
LNW	70,797	71,740	943	56.1%
THH	30,780	31,074	294	17.5%
NWL	245,276	246,958	1,682	100%

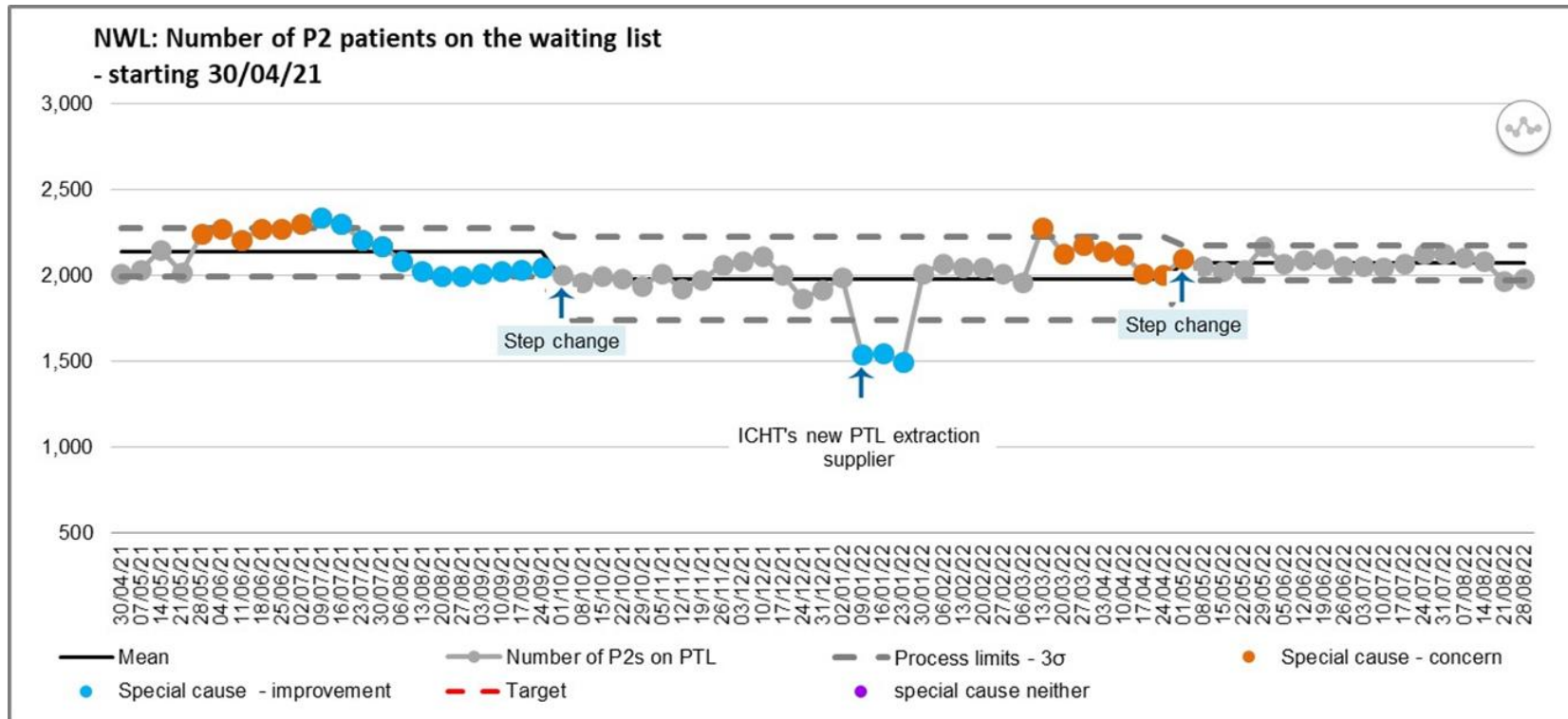
PTL Change by Specialty Top 20 Specialties by PTL Size	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
Ear Nose and Throat Service	22,596	22,890	294	17.5%
Ophthalmology Service	22,051	22,087	36	2.1%
Gynaecology Service	21,498	21,396	-102	-6.1%
Trauma and Orthopaedic Service	15,198	15,505	307	18.3%
Cardiology Service	14,922	14,789	-133	-7.9%
Gastroenterology Service	12,235	12,497	262	15.6%
Urology Service	11,923	11,891	-32	-1.9%
Dermatology Service	11,547	11,768	221	13.1%
General Surgery Service	11,277	11,240	-37	-2.2%
Neurology Service	10,478	10,668	190	11.3%
Colorectal Surgery Service	10,299	10,508	209	12.4%
Respiratory Medicine Service	6,344	6,635	291	17.3%
Vascular Surgery Service	6,377	6,489	112	6.7%
Maxillofacial Surgery Service	6,333	6,349	16	1.0%
Oral Surgery Service	5,634	5,611	-23	-1.4%
Pain Management Service	5,503	5,546	43	2.6%
Neurosurgical Service	5,144	5,173	29	1.7%
Rheumatology Service	5,268	5,145	-123	-7.3%
Endocrinology Service	4,935	4,910	-25	-1.5%
Paediatric Service	3,829	3,834	5	0.3%
Top 20	213,391	214,931	1,540	91.6%

Theatre throughput – 1,296 elective patients received surgery in NWL theatres last week. This is 86.8% of 2019/20 weekly average activity across the system.



N.B. CWHFT changed system in FY 19/20. All Trusts' weekly averages do not include March 2020 as there was a decrease in cases due to Covid-19.
 *The dip at 05/06/22 is due to an ad-hoc 4 day bank holiday weekend.

P2 waiting list size across NWL Trusts: SPC chart



Statistical Process Control charts demonstrate trend of P2 numbers over the last 67 wks.

Aggregated NWL position shows variation over time of P2 patients on waiting lists. This week, variation remains within statistical control limits.

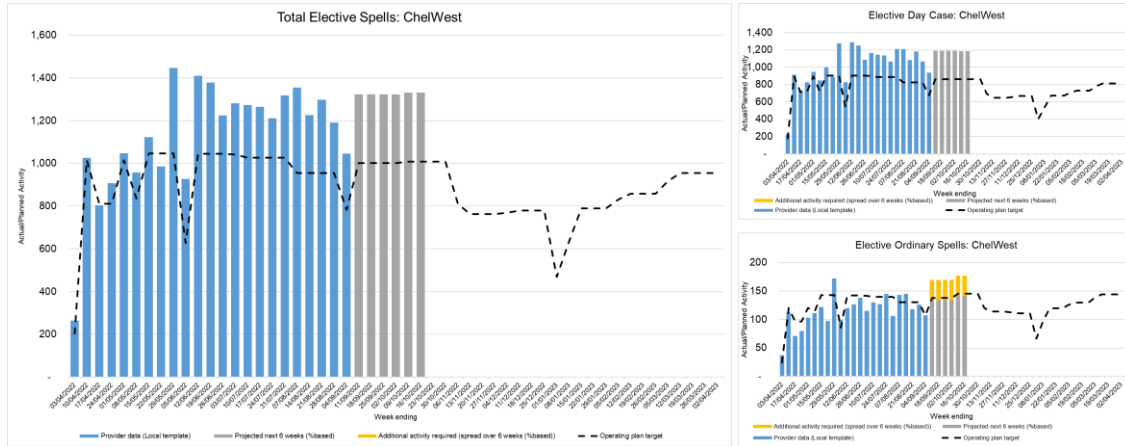
Trust level SPC charts can be found in the appendices.



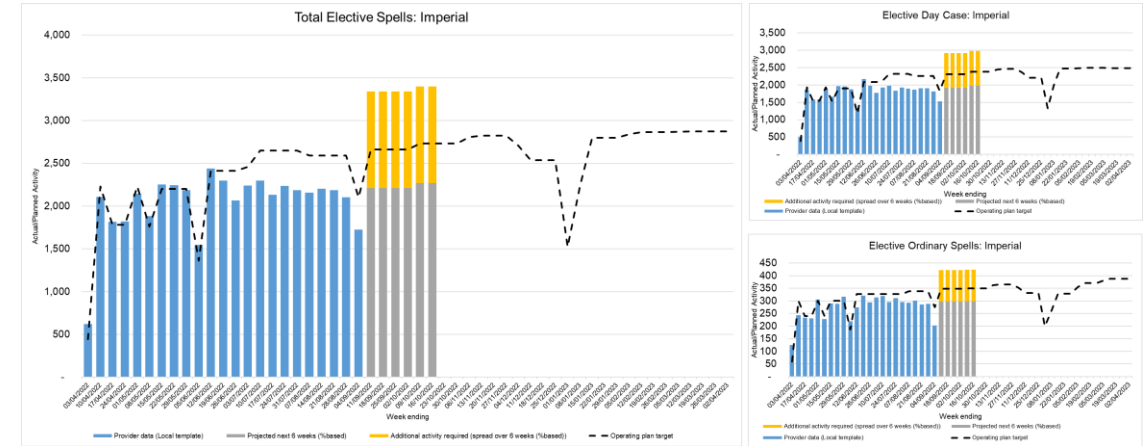
Activity Recovery

Elective Weekly performance by Trust – performance and 6-week forward view

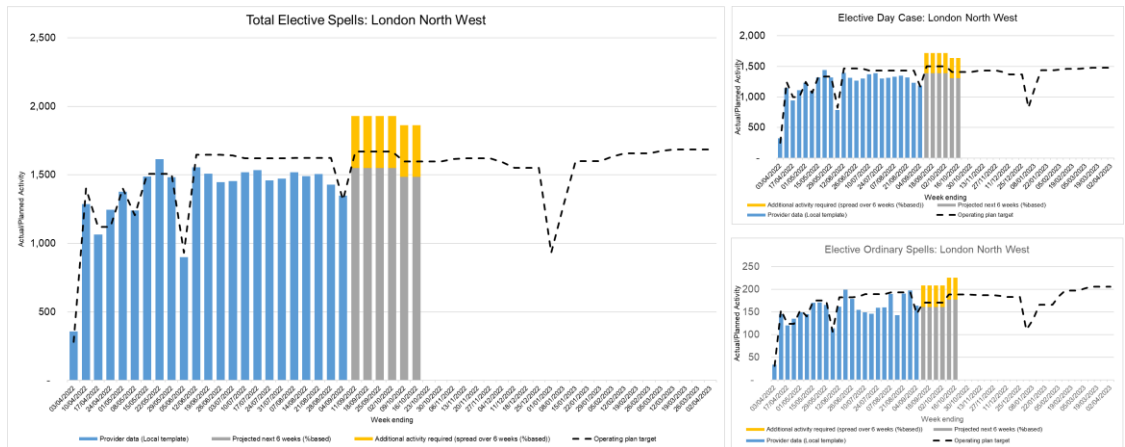
CWFHT



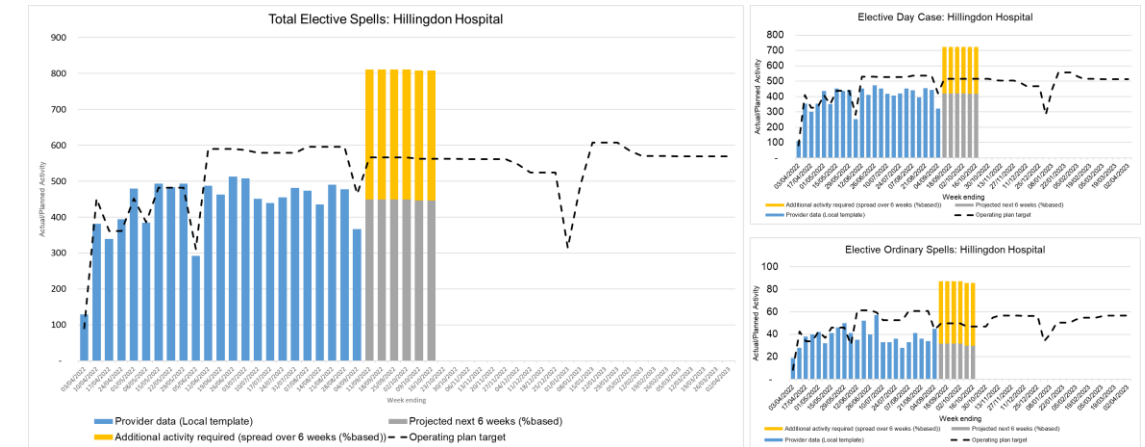
ICHT



LNWUHT



THHT



N.B. This report includes unvalidated operational data which needs to be viewed in conjunction with exception reports from trust teams.

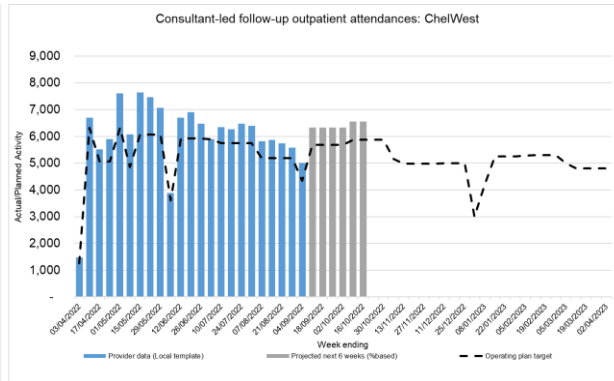
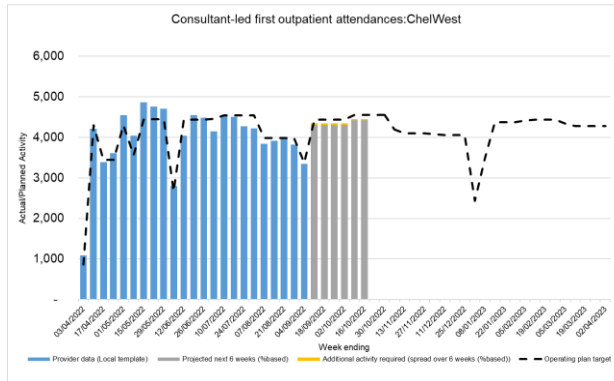
Confidential information - not for further distribution

Source: Provider local template returns

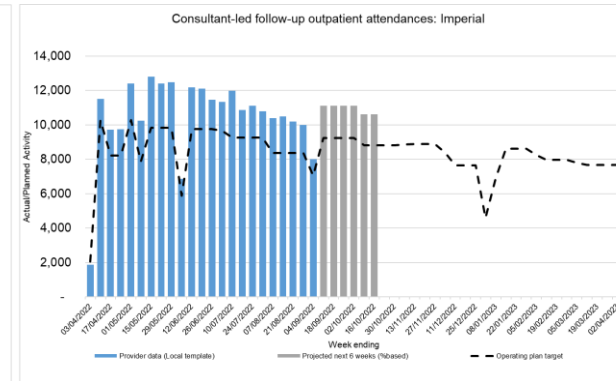
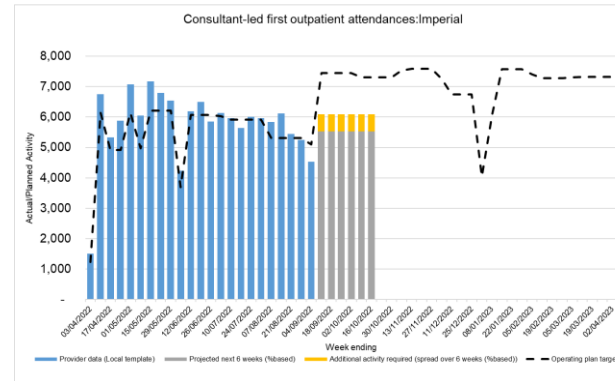
■ Provider data (Local template)
 ■ Projected next 6 weeks (%based)
 ■ Additional activity required (spread over 6 weeks (%based))
 Operating plan target

Consultant-led Outpatients performance and 6-week forward view

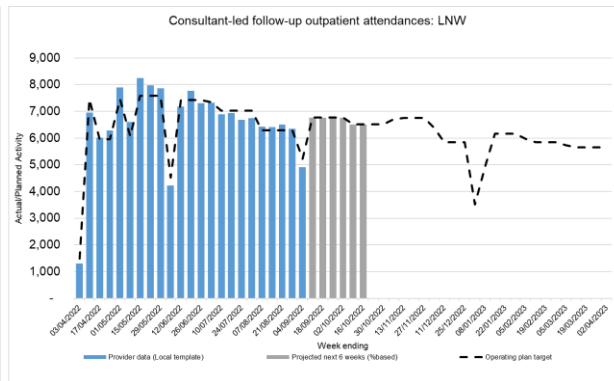
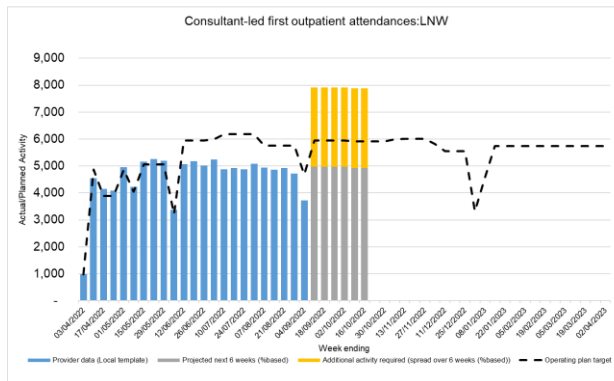
CWFHT



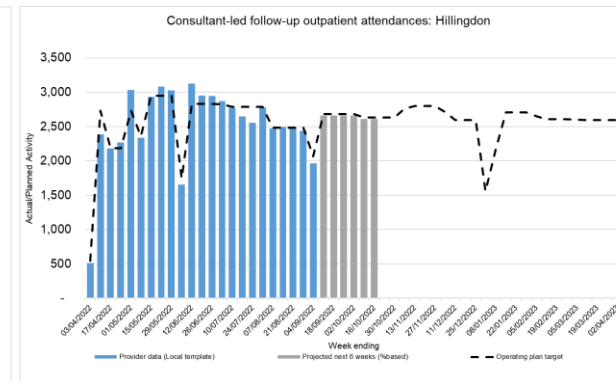
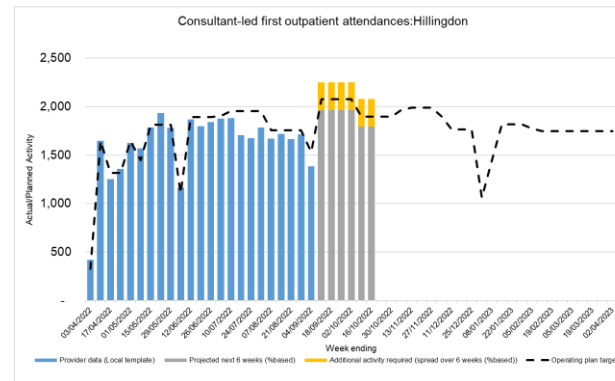
ICHT



LNWUHT



THHFT



N.B. This report includes unvalidated operational data which needs to be viewed in conjunction with exception reports from trust teams.

Confidential information - not for further distribution

Source: Provider local template returns

Advice & Guidance Performance

June 2022: NHS England System EROC Dashboard Data

	Total Requests	Processed Requests	Diverted Requests	Utilisation Rate per 100OPFA	Diversion Rate
CW	14,349	10,292	2,787	49.1	19.4
ICHT	21,110	13,712	3,822	39.7	18.1
LNW	5,970	3,871	1,935	17.5	32.4
THH	13,654	9,824	3,393	95.1	24.2
Other	922	613	221	33,8	24.0

Utilisation Target Rate

Target: 16 per 100 OPFA

Achieved at 3 / 4 NWL Trusts

Significant post-referral advice volumes at CW and ICHT – e.g. RAS Triage clinics

LNW: low use of RAS Triage clinics therefore data unlikely to be visible for triage activity.

Total ICS Diverted Activity (June): **11,324**

Diverted activity is the key measurable for ERF with this activity being 'payable' under the ERF scheme

Note: NHS England have now provided a standard SQL script for generating post-referral A&G activity in a common manner across trusts. This does appear to have increased the amount of activity being recorded this month.

NOTE 2: Disagreement between Trust sourced views and the NHS England EROC view are being investigated with NHS Digital

Pre-referral A&G Activity recorded on Rego: w/c 14 Aug

	Total Requests	Processed Requests	Diverted Requests
CW	294	155	116
ICHT			
LNW	286	143	113
THH	818	575	237

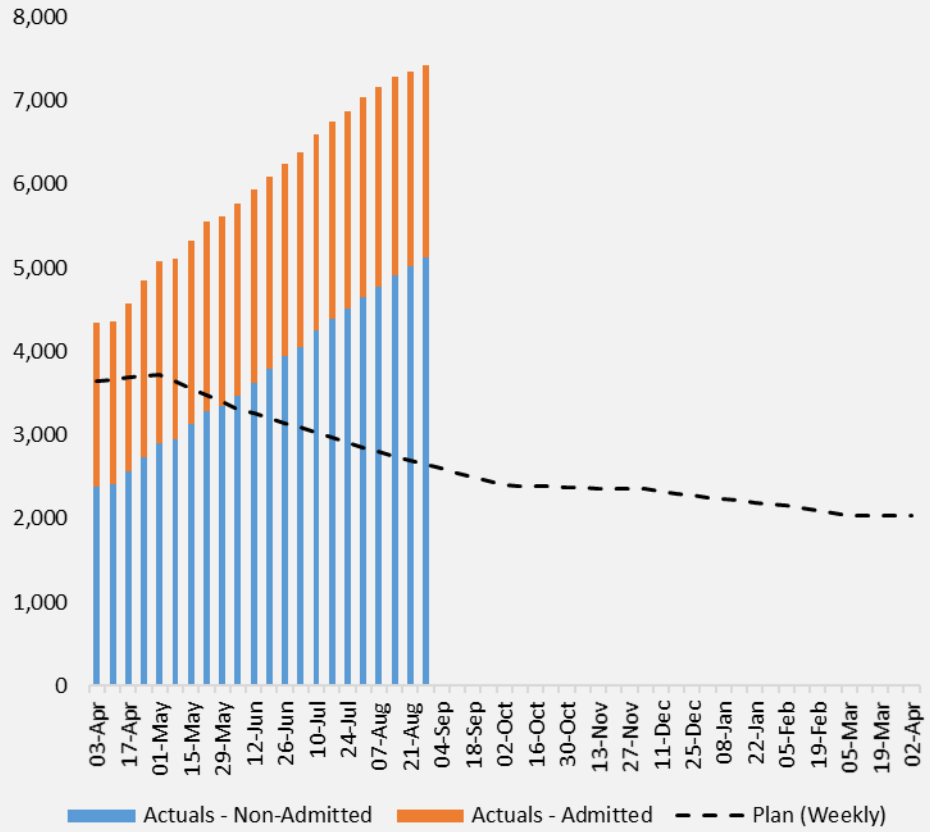
Currently ICS dashboard view combines CW and ICHT data – to be addressed by supplier

Waiting List

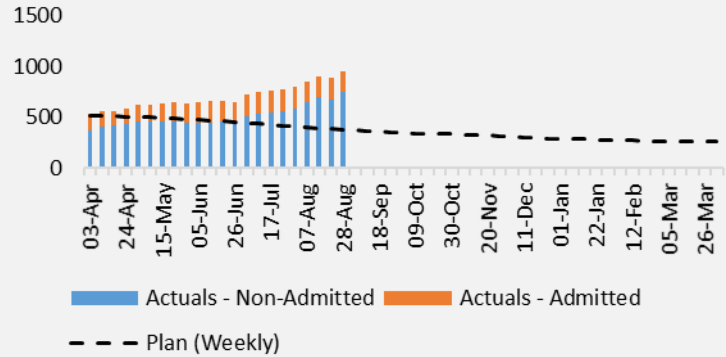
(52ww, 78ww, 104ww monitoring)

52ww by Trust including Operating Plan target trajectory

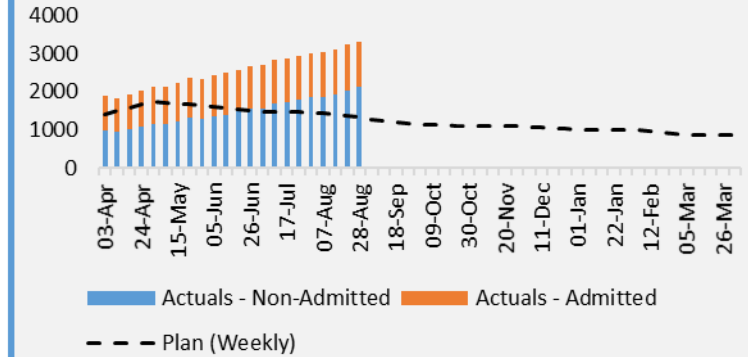
RTT 52 week wait-NWL



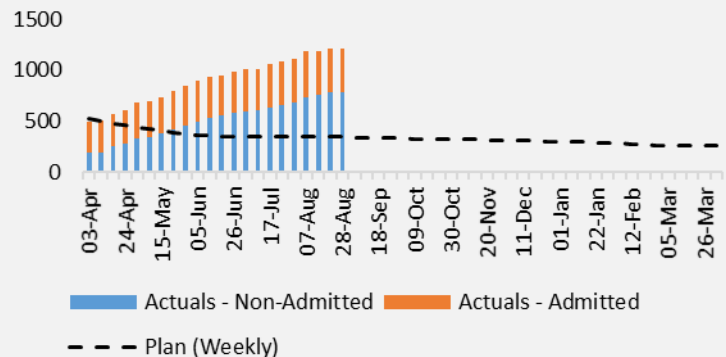
RTT 52 week wait-CWFT



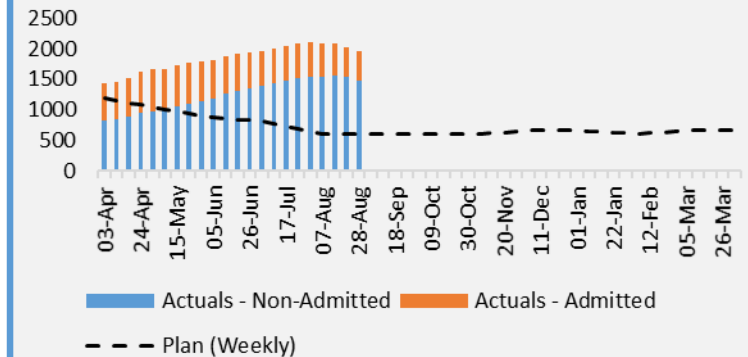
RTT 52 week wait-ICHT



RTT 52 week wait-LNWUHT

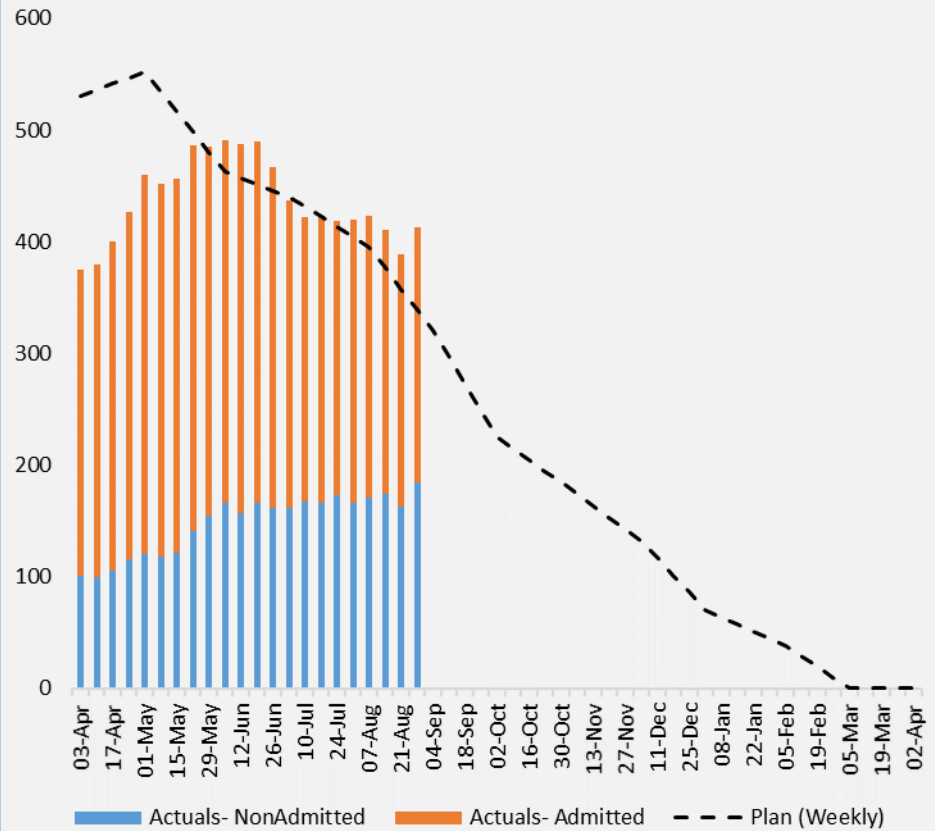


RTT 52 week wait-THHFT

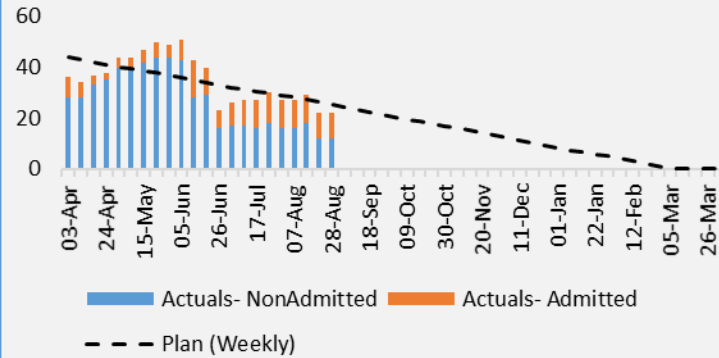


There are currently 413 patients waiting longer than 78 weeks across NWL, which is 74 more than this weeks' required target trajectory to hit zero by March 2023.

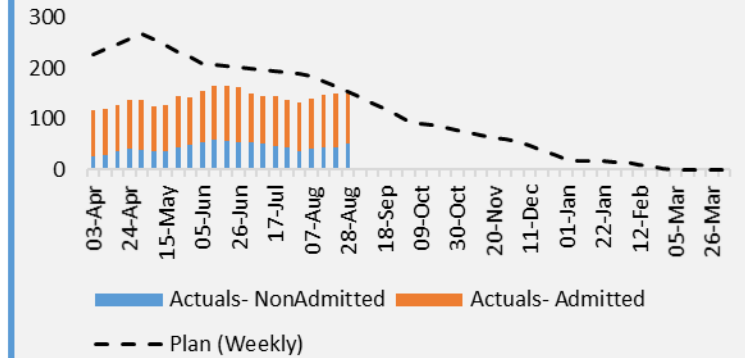
RTT 78 week wait-NWL



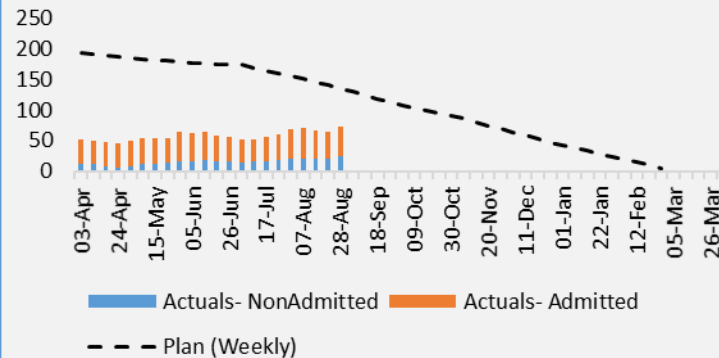
RTT 78 week wait-CWFT



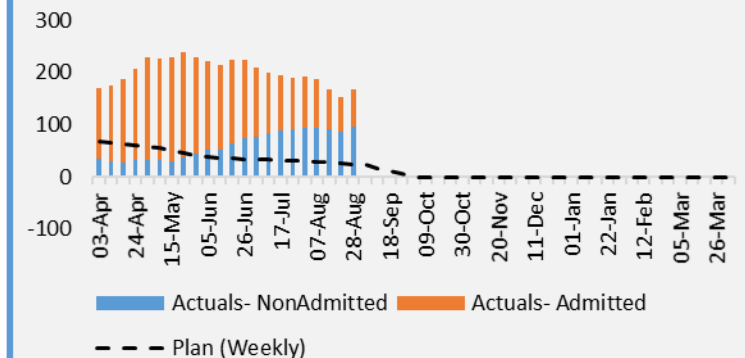
RTT 78 week wait-ICHT



RTT 78 week wait-LNWUHT

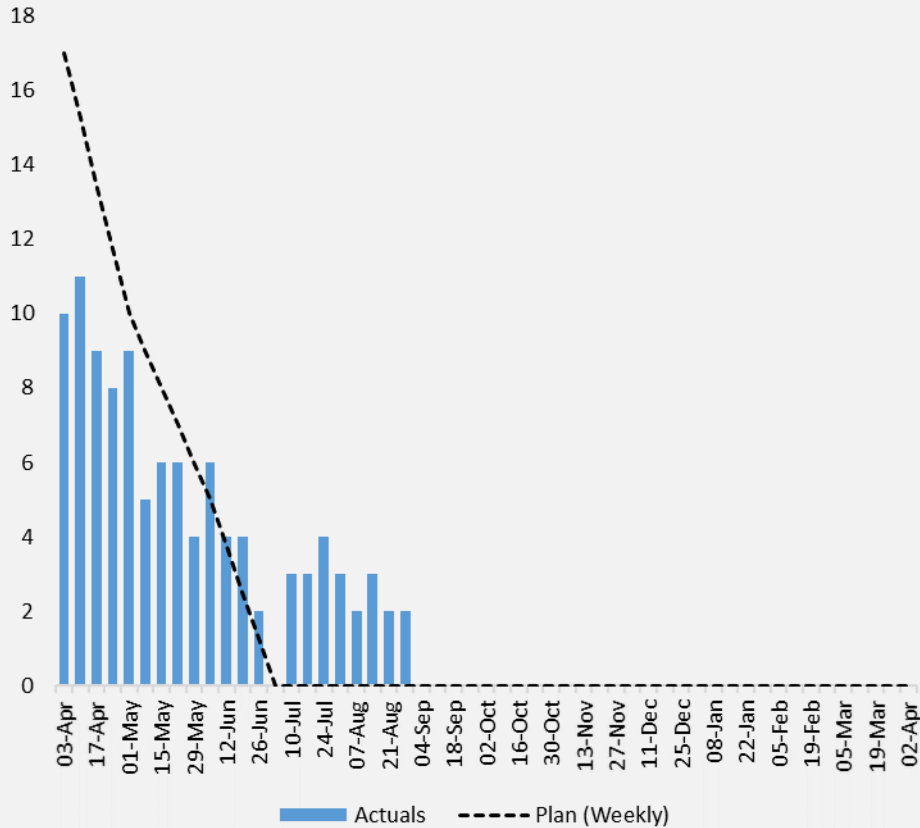


RTT 78 week wait-THHFT

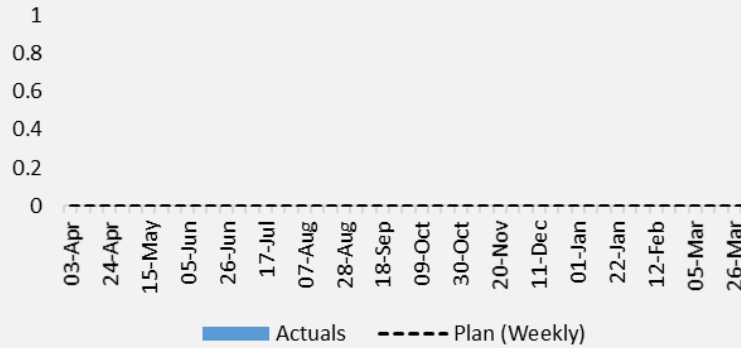


104ww by Trust including Operating Plan target trajectory

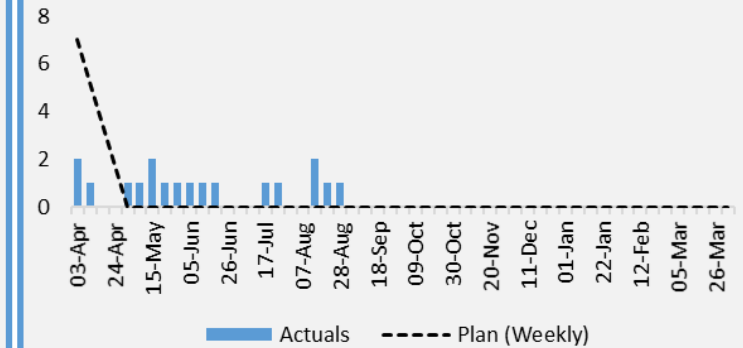
RTT 104 week wait-NWL



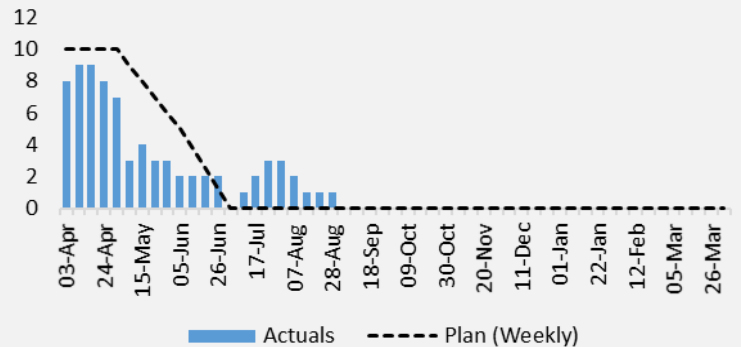
RTT 104 week wait-CWFT



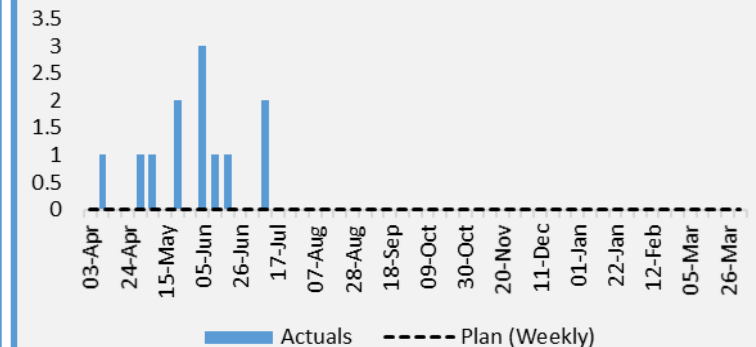
RTT 104 week wait-ICHT



RTT 104 week wait-LNWUHT



RTT 104 week wait-THHFT



PTL Weekly Change – Specialties Highlight

ENT	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	2,925	2,934	9	3.1%
ICHT	5,954	5,950	-4	-1.4%
LNW	10,066	10,205	139	47.3%
THH	3,651	3,801	150	51.0%
NWL	22,596	22,890	294	100%

T&O	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	4,108	4,177	69	22.5%
ICHT	2,690	2,714	24	7.8%
LNW	4,332	4,414	82	26.7%
THH	4,068	4,200	132	43.0%
NWL	15,198	15,505	307	100%

Gastro	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	3,148	3,241	93	35.5%
ICHT	3,155	3,187	32	12.2%
LNW	4,636	4,784	148	56.5%
THH	1,296	1,285	-11	-4.2%
NWL	12,235	12,497	262	100%

Derm	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	2,928	3,043	115	52.0%
ICHT	4,568	4,584	16	7.2%
LNW	3,401	3,444	43	19.5%
THH	650	697	47	21.3%
NWL	11,547	11,768	221	100%

Colorectal	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	1,890	1,909	19	9.1%
ICHT	3,264	3,250	-14	-6.7%
LNW	4,673	4,863	190	90.9%
THH	472	486	14	6.7%
NWL	10,299	10,508	209	100%

Resp	2022-08-21	2022-08-28	Change #	% of NWL PTL Change
CW	1,137	1,347	210	72.2%
ICHT	3,096	3,110	14	4.8%
LNW	1,351	1,428	77	26.5%
THH	760	750	-10	-3.4%
NWL	6,344	6,635	291	100%

52wk Non-Adm Weekly Change by Specialty

Non-Admitted >52wk waiters grew by 138 (2.1%) in 28/08/22.

The below 3 specialties had an 110 increase:

- Allergy (46)
- Rheumatology (37)
- Derm (27)

ENT reduced >52wks by 37.

Non-Adm >52wk Change by Prov All Specialties	2022-08-21	2022-08-28	Change #	% of NWL >52wk Change
CW	674	744	70	66.7%
ICHT	2,029	2,117	88	83.8%
LNW	783	786	3	2.9%
THH	1,534	1,478	-56	-53.3%
NWL	5,020	5,125	105	100%

Non-Adm >52wk Change by Specialty Top 20 Specialties by >52wk Size	2022-08-21	2022-08-28	Change #	% of NWL >52wk Change
Ear Nose and Throat Service	618	581	-37	-35.2%
Allergy Service	472	518	46	43.8%
Gynaecology Service	481	481	0	0.0%
Rheumatology Service	394	431	37	35.2%
Neurosurgical Service	436	429	-7	-6.7%
Urology Service	400	396	-4	-3.8%
Vascular Surgery Service	388	388	0	0.0%
Pain Management Service	328	317	-11	-10.5%
Neurology Service	287	288	1	1.0%
Colorectal Surgery Service	258	269	11	10.5%
General Surgery Service	210	223	13	12.4%
Ophthalmology Service	134	150	16	15.2%
Dermatology Service	99	126	27	25.7%
Trauma and Orthopaedic Service	115	117	2	1.9%
Plastic Surgery Service	85	90	5	4.8%
Oral Surgery Service	62	62	0	0.0%
Cardiology Service	49	49	0	0.0%
Maxillofacial Surgery Service	32	33	1	1.0%
Gastroenterology Service	29	33	4	3.8%
Paediatric Ear Nose and Throat Service	29	23	-6	-5.7%
Top 20	4,906	5,004	98	93.3%

Non-Adm 52wk Clearance Rates

Non-Adm >52wk Top 10 Specs by >52wks	>52wks	>52wks Clock Stops	>52wks Weeks to Clear *	40-52wks	40-52wks Clock Stops	40-52wks Weeks to Clear *	52kw Cohort in 12wks	Estimated Clock Stops	Estimated 52wks in 12wks
ENT	581	32	18	1,879	41	46	2,460	876	1,584
Allergy Service	518	2	259	564	4	141	1,082	72	1,010
Gynaecology Service	481	36	13	976	29	34	1,457	780	677
Rheumatology Service	431	17	25	379	8	47	810	300	510
Neurosurgical Service	429	12	36	567	6	95	996	216	780
Urology Service	396	30	13	676	34	20	1,072	768	304
Vascular Surgery Service	388	35	11	597	19	31	985	648	337
Pain Management Service	317	12	26	403	5	81	720	204	516
Neurology Service	288	9	32	1,084	34	32	1,372	516	856
Colorectal Surgery Service	269	4	67	487	9	54	756	156	600
Top 10 Specialties	4,098	189	22	7,612	189	40	11,710	4,536	7,174

Largest number of tips ins over next 12 weeks:
 ENT (1,879),
 Neurology (1,084)
 Gynae (976)

ICHT (4,490) have the highest number of tips over next 12 weeks.

The estimated highest number 52wk waits in 12 weeks:

- ENT by specialty (581 to 1,584)
- ICHT by provider (2,117 to 3,931)

Non-Adm >52wk All Specialties	>52wks	>52wks Clock Stops	>52wks Weeks to Clear *	40-52wks	40-52wks Clock Stops	40-52wks Weeks to Clear *	52kw Cohort in 12wks	Estimated Clock Stops	Estimated 52wks in 12wks
ICHT	2,117	97	22	4,490	126	36	6,607	2,676	3,931
THH	1,478	52	28	2,779	41	68	4,257	1,116	3,141
LNW	786	52	15	3,084	101	31	3,870	1,836	2,034
CW	744	39	19	2,067	120	17	2,811	1,908	903
NWL	5,125	240	21	12,420	388	32	17,545	7,536	10,009

* Please note that 'weeks to clear' is based on clocks stops, which are an undercount of true levels.

Appendix 1 – Trust Confidence Dashboards

CWHFT – Delivery confidence medium to high.

Most recent data available as of 28/08/2022

Area	Metric	Current Performance (from 27/03/2022)	Plan	Confidence of delivery	Driver of current position	Mitigations
P2s	P2 waiting list size	WE-28-08-2022 541	Maintain P2 waiting list size between 444 and 531 pts	Currently 448	P2 waiting list size remains consistent with capacity to treat in all specialties. Patients waiting over 6 weeks have had clinical harm reviews with none identified.	Reviewed by specialties' using Foundry and escalated through internal 6-4-2 meeting.
Long Waiters	Number of 78ww	WE-28-08-2022 397	Remove 66 patients / wk	Current 78ww 22 Avg removals last 4 wks 225	Trajectory to reduce 78ww remains on plan. Vascular surgery drives majority of these and capacity now on-board to address these patients. Focus on tip overs to finally eliminate the over 78 week waiters in line with trajectory.	Patients validated and next clinic date or operative date in place or booked through internal performance meetings and trust access meeting.
	Number of 52ww	WE-28-08-2022 22	Reduce to 255 patients by March 2023	Current 52ww 953 Current week target 378	Tip overs are adding to the position in a number of specialties, particularly for those on a non-admitted pathway. As capacity becomes available as the longer waiting patients are treated we will start to see this cohort reduce, however this may not be until October.	
Admitted	Admitted PTL size	WE-28-08-2022 6,691	Reduction trajectory over the past 3 months	Currently 6,342 3 month growth -2.0%	Admitted PTL remains static with sufficient capacity to treat patients in all specialties. Pressure in vascular over past few months but capacity returned.	Reviewed at divisional performance and trust elective access meetings. Focus on theatre productivity and additional diagnostic capacity to mitigate risk.
	Elective Total Activity	WE-28-08-2022 6,280	107% of BAU	4wk avg. 133% Current wk % 143% Pts seen this wk 1,191	Elective activity improving following August holidays, prospective booking encouraging compared to elective plan in the majority of specialties.	New IPC guidance in place and implementation of ASA fast track and late availability lists being made available through Foundry has made an impact on filling last minute cancellations from patients.
Non-Admitted	Non-Admitted PTL size	WE-28-08-2022 43,886	Reduction trajectory over the past 3 months	Currently 43,724 3 month growth 3.8%	Referrals returned to pre COVID levels for all specialties for non-cancer patients as well now. Increasing cancer referrals remain above baseline in almost all specialties. Focus remains on outpatient new activity and booking clinics to capacity and DNA rates.	Ensuring all clinics are fully booked and templates reflect agreed new and f/up slots agreed through the CRGs.
	Outpatients First Activity	WE-28-08-2022 41,025	107% of BAU	4wk avg. 99% Current wk % 115% Pts seen this wk 3,825	Outpatients activity impacted by recent holidays, however still achieved the operating plan ambition for OP NEWs and seeing a reduction in follow ups.	
	Outpatients F/Up Activity	WE-28-08-2022 64%	> 75% of BAU	4wk avg. 74% Current wk % 86% Pts seen this wk 5,584	As above, except implementation of PIFU pathways in remaining specialties expected to support reduced follow up activity.	Future bookings show an improvement in this position. Work to reduce f/up activity and replace with new underway.



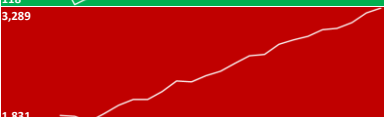





RAG rating key
0% - 5%
5% - 10%
10% +



Sources: NHS ICS RTT Tool & WAR monitoring report

ICHT – Delivery confidence medium, with the impact of Western Eye being mitigated.

Most recent data available as of 28/08/2022

Area	Metric	Current Performance (from 27/03/2022)	Plan	Confidence of delivery	Driver of current position	Mitigations
P2s	P2 waiting list size	 1,074 830	Maintain P2 waiting list size between 876 and 1,046 pts	Currently 861	Main P2s are surgery & cardiology patients. Median number increased in the new year, but quickly stabilised and remains within sustainable limits based on the number of P2s treated each week.	P2 theatre capacity ring-fenced and protected. Weekly validation & review cycle with DD & DDO oversight. Executive escalation & oversight of overdue patients. Close coordination with clinical harm review process. Theatre utilisation improvement work.
	Number of 78ww	 166 118	Remove 178 patients / wk	Current 78ww 151 Avg removals last 4 wks 563	Competing pressures to maintain P2 and cancer pathway times has constrained capacity to reduce long waiters in some specialties. COVID pathway constraints in clinics has reduced capacity to quickly reduce non-admitted long waiters.	Weekly validation & review cycle with DD & DDO oversight. Additional theatre capacity procured (Vanguard & IS) Trajectory for 78ww remains to be at zero by end of Mar 23.
Long Waiters	Number of 52ww	 1,831 3,289	Reduce to 856 patients by March 2023	Current 52ww 3,289 Current week target 1,320	Re-profiled 52ww position not met in June/July, with around 400 patients tipping in each month.	Long waiter lists are reviewed every week on a patient by patient basis. CEO specialty deep dives taking place in September, trying to shift focus towards 52ww as 78ww position is continuing to improve.
	Admitted PTL size	 11,234 10,351	Reduction trajectory over the past 3 months	Currently 10,925 3 month growth 0.5%	Internal data indicates 1.7% growth in the last 3 months, driven principally by a return to pre-COVID referral levels.	Weekly review cycle with DD & DDO oversight. Anticipate changes in IPC guidance will permit increased clinic and theatre throughput.
Admitted	Elective Total Activity	 113% 65%	107% of BAU	4wk avg. 96% Current wk% 111% Pts seen this wk 2,103	IPC guidelines impact on theatre and clinic throughput. WEH theatre closure impact on capacity, not just in Ophthalmology. Changes to theatre allocation and case mix in anticipation of Sector HVLC hubs which have not yet been fully established. Difficulty obtaining staff to meet required WLLs, compounded by increased anaesthetic sickness levels.	Weekly review cycle with DD & DDO oversight. Additional capacity procured for admitted and non-admitted activity (Vanguard, IS & IS insourcing). IS capacity for ophthalmology. Change in IPC guidelines will permit and increase throughput.
	Non-Admitted PTL size	 83,113 74,844	Reduction trajectory over the past 3 months	Currently 83,113 3 month growth 4.0%	Referrals have returned to pre-COVID levels, but IPC guidelines have constrained clinic capacity and ability to respond fully.	
Non-Admitted	Outpatients First Activity	 129% 54%	107% of BAU	4wk avg. 119% current wk % 128% Pts seen this wk 5,251	Apparent near-term drop under investigation. OP activity has been consistently at about 110% pre-COVID in Q3 and Q4.	Anticipate changes in IPC guidance will permit increased clinic and throughput.
	Outpatients F/Up Activity	 155% 59%	> 75% of BAU	4wk avg. 107% Current wk % 129% Pts seen this wk 9,986		Ongoing OP improvement programme includes initiatives to improve A&G/A&R, and reduce follow-ups. Procured additional capacity (IS insourcing).






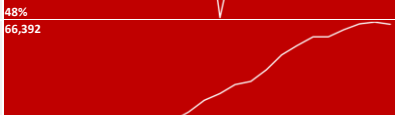


RAG rating key
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10% +



Sources: NHSL ICS RTT Tool & WAR monitoring report

LNWUHT – Delivery confidence medium.

Most recent data available as of 28/08/2022

Area	Metric	Current Performance (from 27/03/2022)	Plan	Confidence of delivery	Driver of current position	Mitigations
P2s	P2 waiting list size		Maintain P2 waiting list size between 455 and 505 pts	Currently 479	Position remains stable within control levels. Further reviews underway to validate P coding across Divisions with Deputy CMO oversight.	Weekly reviews at Divisional level and RTT Validation Team oversight with Deputy CMO.
	Number of 78ww		Remove 78 patients / wk	Current 78ww 72 Avg removals last 4 wks 253	Position remains within our operating plan trajectory but continues to increase. There is a risk of continued increase as the 52ww position continues to grow.	Weekly validation in place. +78 week tracker in place reviewed with specialties weekly.
Long Waiters	Number of 52ww		Reduce to 260 patients by March 2023	Current 52ww 1218 Current week target 343	PTL profile is driving the tip over position linked to: - referral volumes following covid recovery surges; - continued +200% increase in cancer demand.	Mitigations not able to reduce the growth. Range of validation specialties in place including increased use of text messages and stricter use of access policy. Continued focus on OPA and theatre productivity.
	Admitted PTL size		Reduction trajectory over the past 3 months	Currently 5,348 3 month growth 4.9%	Variation seen over past 3 months now showing signs of stabilisation.	
Admitted	Elective Total Activity		107% of BAU	4wk avg. 91% Current wk % 95% Pts seen this wk 1,428	Substantive capacity in place for 160 of 192 planned weekly 4hr lists. Remainder reliant on WLIs.	Ongoing recruitment. Continued focus on activity recording in line with baseline. Endoscopy productivity plan on target.
	Non-Admitted PTL size		Reduction trajectory over the past 3 months	Currently 66,392 3 month growth 14.2%	Rising referrals, digital delays with interface systems and DNA rate.	PTL validation actions underway. Focus on removing duplicates, use of access policy, DNA reduction through text message, phone call reminders and updating patient letters. Use of A&G. Reviewing N:FU ratios to support an increase in 1st OPAs. Digital actions underway.
Non-Admitted	Outpatients First Activity		107% of BAU	4wk avg. 104% Current wk % 120% Pts seen this wk 4,711	Trust has recovered to 100% of baseline activity. Ops plan requirement to move to 120% by M4.	Continued focus on OPA productivity. Continued focus on activity recording.
	Outpatients F/Up Activity		> 75% of BAU	4wk avg. 80% Current wk % 96% Pts seen this wk 6,344	Trust has recovered to 100% of baseline activity. Ops plan requirement to move to 75% by M4.	Planning underway to switch template capacity to increase First OPA, review clinical variation across N:FUs. Continued focus on activity recording.



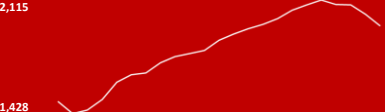


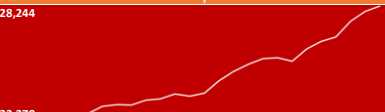


RAG rating key
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 10% +



Sources: NHSL ICS RTT Tool & WAR monitoring report

THHFT – Delivery confidence medium.

Most recent data available as of 28/08/2022

Area	Metric	Current Performance (from 27/03/2022)	Plan	Confidence of delivery	Driver of current position	Mitigations
P2s	P2 waiting list size	 226 132	Maintain P2 waiting list size between 119 and 193 pts	Currently 194	Current P2 position is stable, focus on patients over 6 weeks and ensuring patients are being appropriately prioritised.	P2 theatre capacity ring-fenced and protected. Weekly validation. Escalation & oversight of overdue patients. Close coordination with clinical harm review process.
	Number of 78ww	 238 152	Remove 101 patients / wk	Current 78ww 168 Avg removals last 4 wks 244	Majority of the over 78ww are in Chronic Pain service, where there are ongoing actions to reduce. Other specialities have been impacted by focus on cancer and P2s. ENT is a area of concern and mutual aid and IS support is being explored.	Trajectory for 78 weeks waits is still to be 0 by March 2023. Weekly review of all patients. Pain team putting on additional activity to reduce waits and have own trajectory. Discussions with LNWH to support with ENT pathways underway.
Long Waiters	Number of 52ww	 2,115 1,428	Reduce to 660 patients by March 2023	Current 52ww 1,960 Current week target 607	Increases expected whilst working from longest waiters downwards. Expectation that this will come back inline with target trajectory.	Validation letters have been sent out to patients.
	Admitted PTL size	 3,231 2,828	Reduction trajectory over the past 3 months	Currently 2,830 3 month growth -6.5%	Seeing a reduction in overall admitted PTL as theatre productivity improves.	Weekly oversight meetings with Deputy COO. Changes in IPC guidance will permit increased theatre throughput and reduction in cancellations.
Admitted	Elective Total Activity	 101% 56%	107% of BAU	4wk avg. 91% Current wk % 98% Pts seen this wk 477	High volume of sickness in admissions team causing delay in bookings. Exploring activity recording gaps in medical specialities.	Daily activity oversight meetings with Deputy COO. Changes in IPC guidance will permit increased theatre throughput and reduction in cancellations. Additional resource in theatre booking teams and services supporting. Medical daycases being investigated as not all being captured. currently working through recovery plans at speciality level looking at potential activity to be delivered in August/September.
	Non-Admitted PTL size	 28,244 22,370	Reduction trajectory over the past 3 months	Currently 28,244 3 month growth 15.9%	Referrals have returned to pre-COVID levels, but IPC guidelines have constrained clinic capacity and ability to respond fully. Short term issue with ERS being added to PTL now resolved and additions are BAU increases.	Anticipate changes in IPC guidance will permit increased clinic and throughput. Ongoing OP improvement programme includes initiatives to improve A&G/A&R, and reduce f/ups. Plan in place for a patient validation initiative. As PIFU picks up, expecting to see follow ups reduce.
Non-Admitted	Outpatients First Activity	 140% 64%	107% of BAU	4wk avg. 111% Current wk % 140% Pts seen this wk 1,716	OP 1st are in line with plan now as clinics back on line and increased bookings.	As PIFU picks up, expecting to see follow ups reduce.
	Outpatients F/Up Activity	 134% 55%	> 75% of BAU	4wk avg. 93% Current wk % 114% Pts seen this wk 2,438	Still a high volume of f/ups on backlog that are being prioritised.	

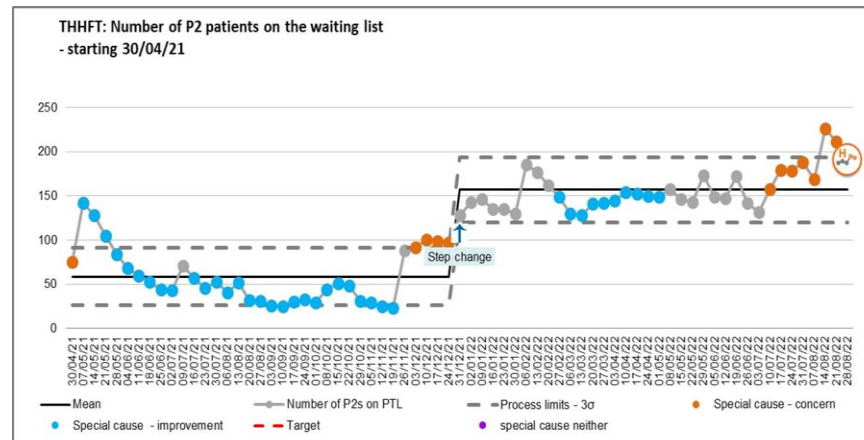
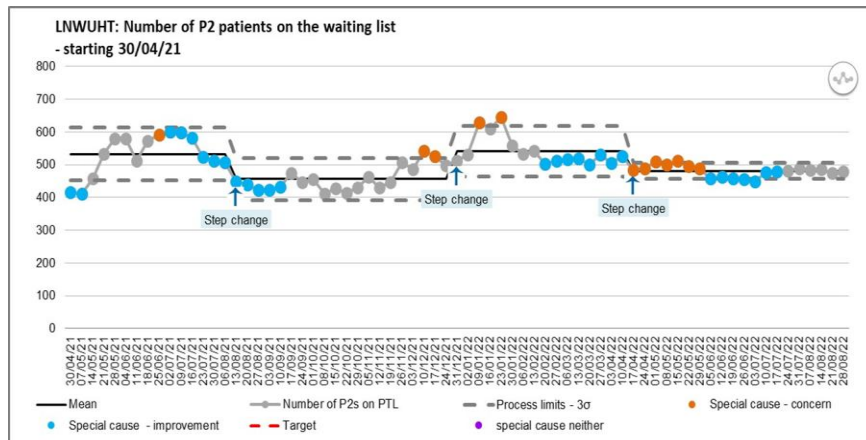
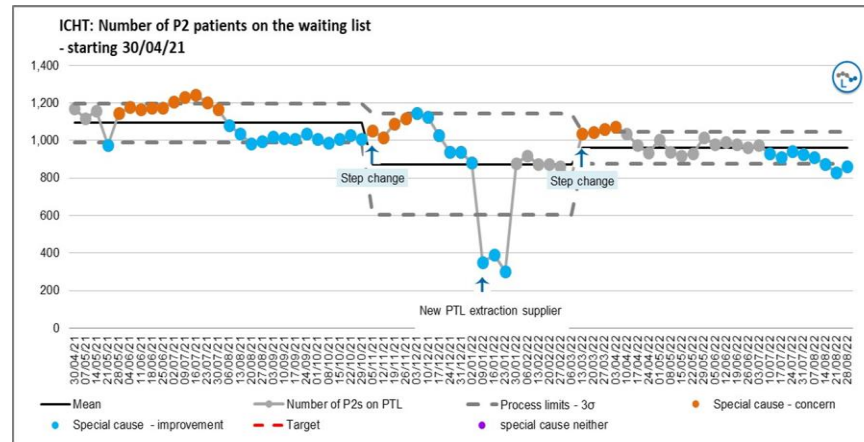
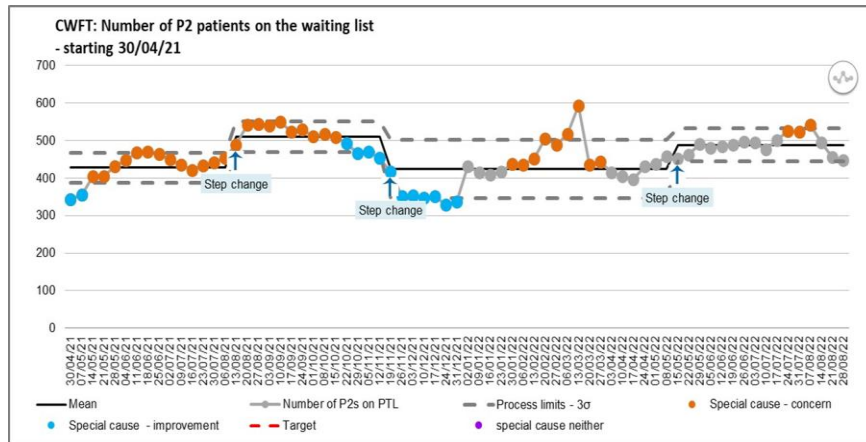
RAG rating key
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Sources: NHSL ICS RTT Tool & WAR monitoring report

Appendix 2 - P2 Risk Mitigation

P2 waiting list size at each Trust: SPC charts



Statistical Process Control charts demonstrate variation of P2 numbers over the last 67 wks and any trends.

All the Trusts show variation over time of P2 patients on waiting lists.

P2 waiting list size across NWL Trusts

Trusts	07/08/2022	14/08/2022	21/08/2022	28/08/2022
CWFT	541	494	455	448
ICHT	912	874	830	861
LNWUHT	484	485	474	479
THHT	169	226	211	194
NWL Total	2,106	2,079	1,970	1,982

P2 patients waiting 6 weeks or more

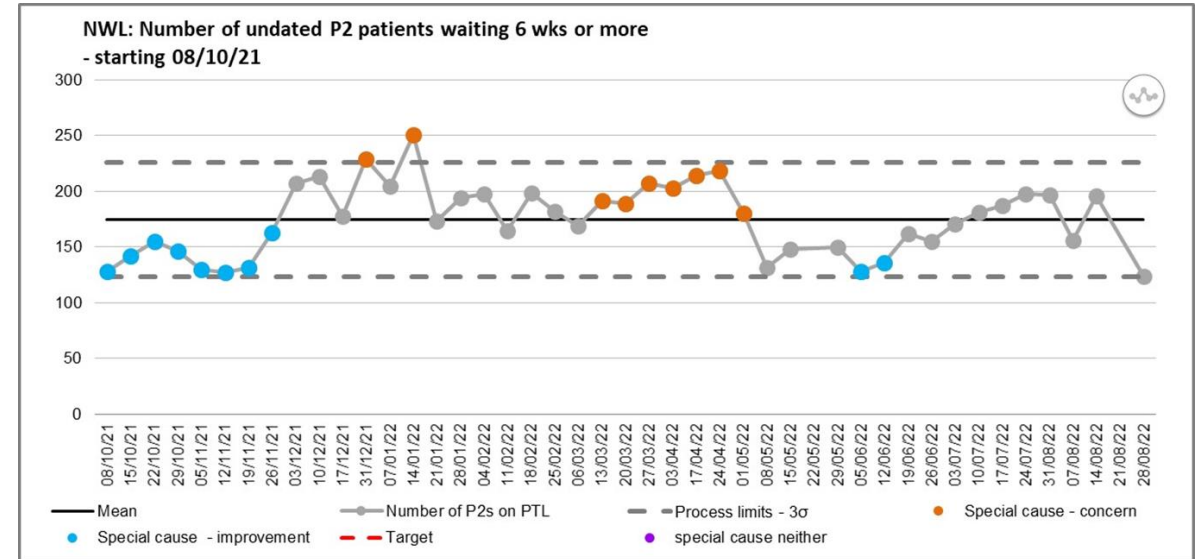
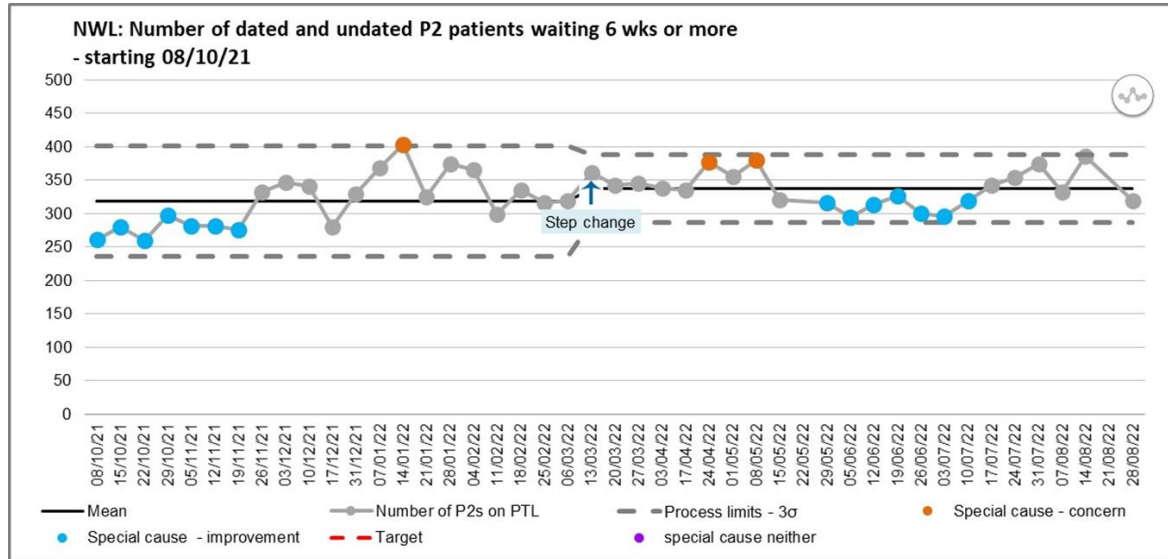
Number of P2 patients waiting 6 weeks or more

P2 6wks								
Trust	10/07/2022	17/07/2022	24/07/2022	31/07/2022	07/08/2022	14/08/2022	21/08/2022	28/08/2022
CWFT	18	23	22	31	34	34		32
ICHT	120	119	131	131	108	140	181	110
LNWUHT	145	160	166	181	157	161	170	121
THHFT	36	40	35	32	33	51	50	57
NWL Total	319	342	354	375	332	386		320

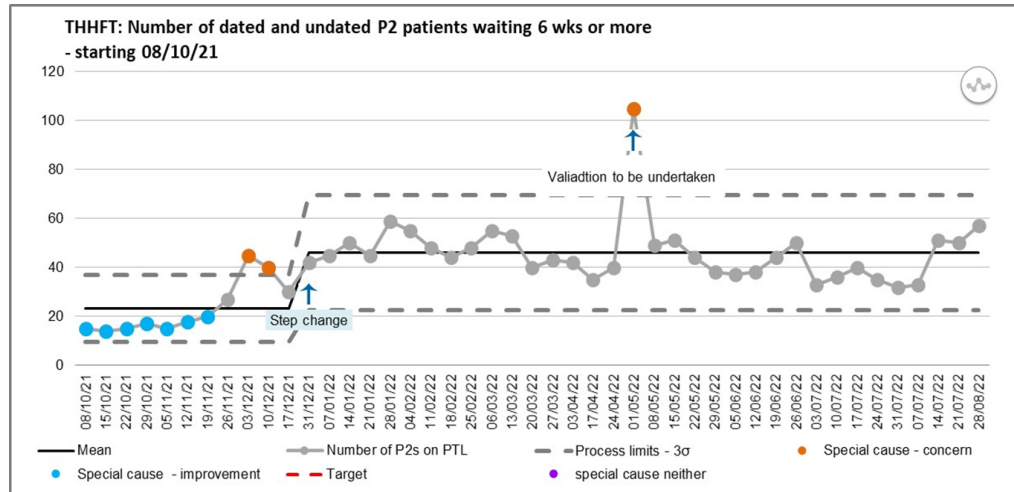
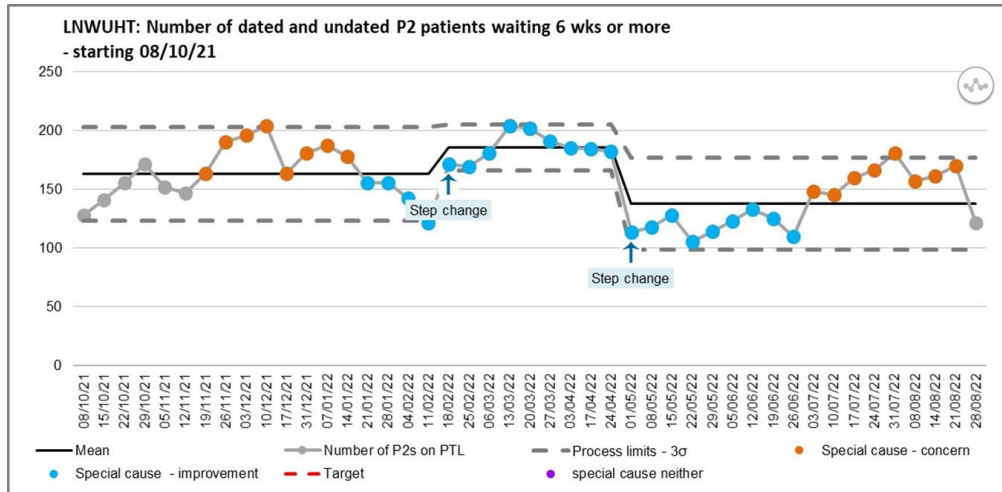
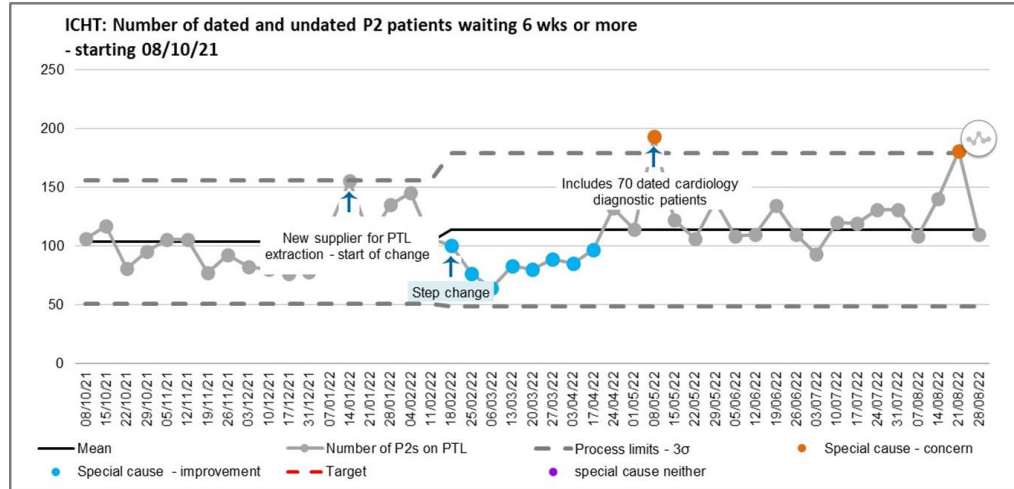
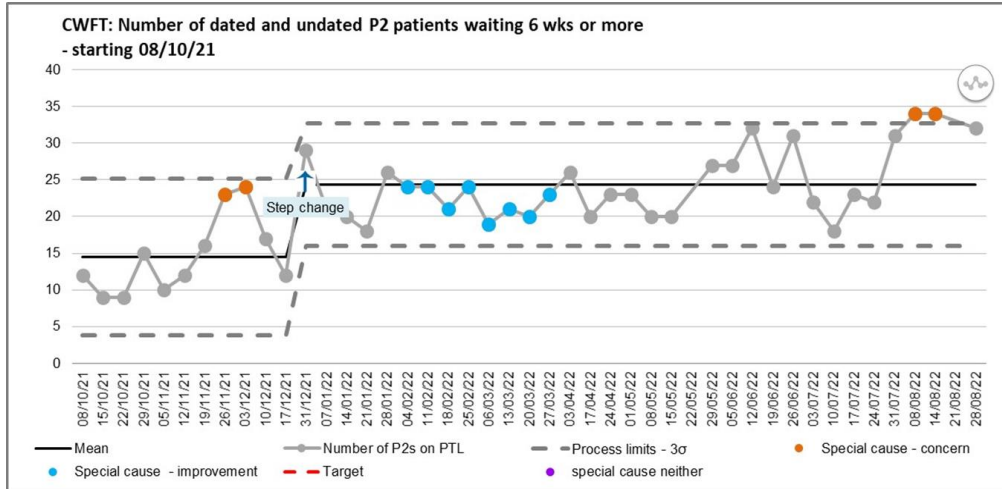
Undated P2 patients waiting 6 weeks or more

Undated	10/07/2022		17/07/2022		24/07/2022		31/07/2022		07/08/2022		14/08/2022		21/08/2022		28/08/2022	
Trust	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL
CWFT	4	1%	4	1%	4	1%	7	1%	12	2%	12	2%			8	2%
ICHT	52	6%	51	6%	53	6%	53	6%	38	4%	70	8%	46		35	4%
LNWUHT	104	22%	114	24%	119	25%	119	24%	86	18%	82	17%	95		48	10%
THHFT	21	13%	18	10%	22	12%	18	10%	20	12%	32	14%	32		33	17%
NWL Total	181	9%	187	9%	198	9%	197	9%	156	7%	196	9%			124	6%

P2 patients waiting 6 weeks or more 2

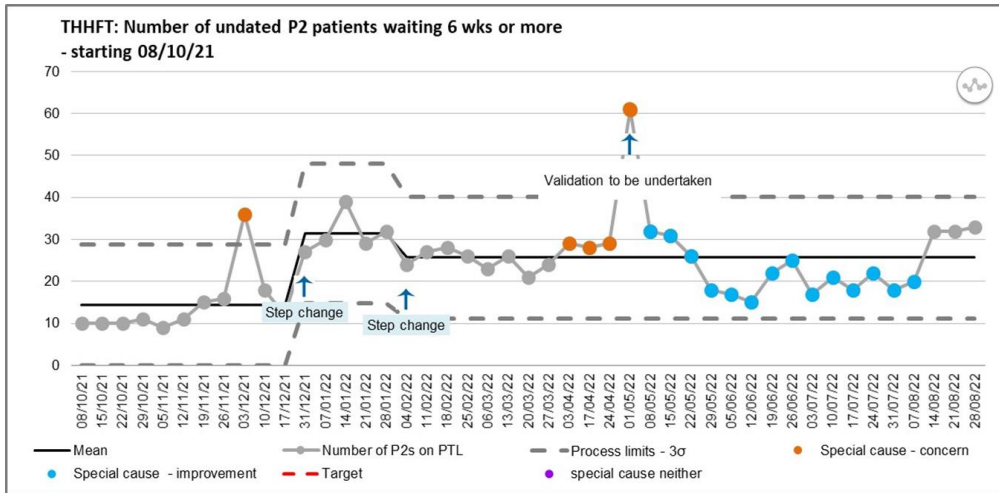
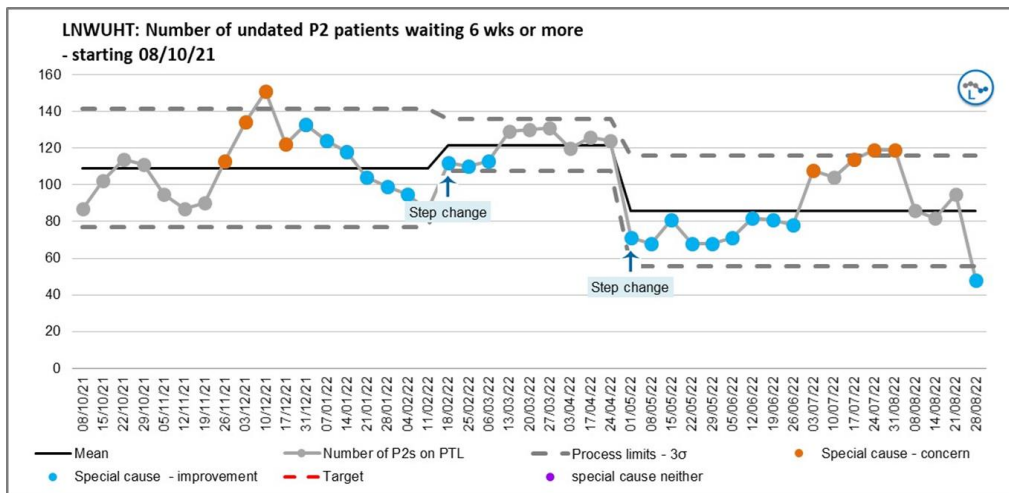
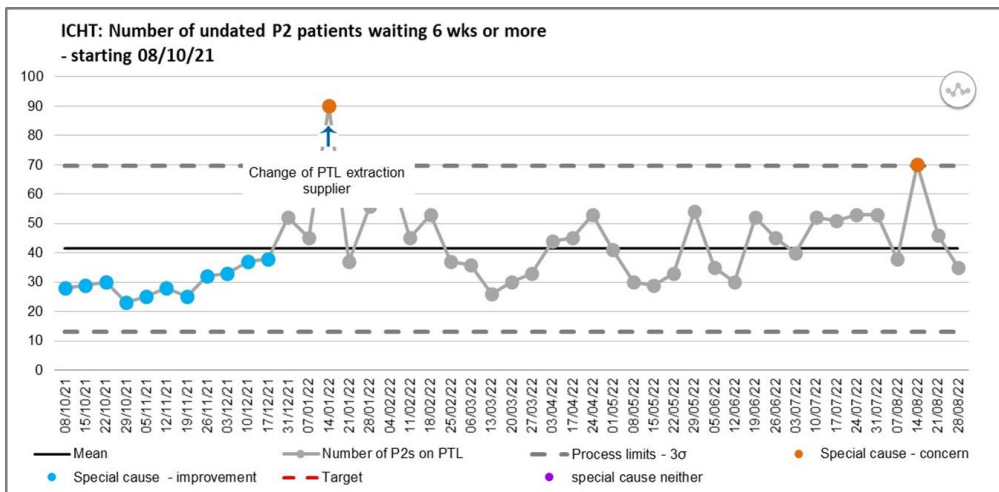
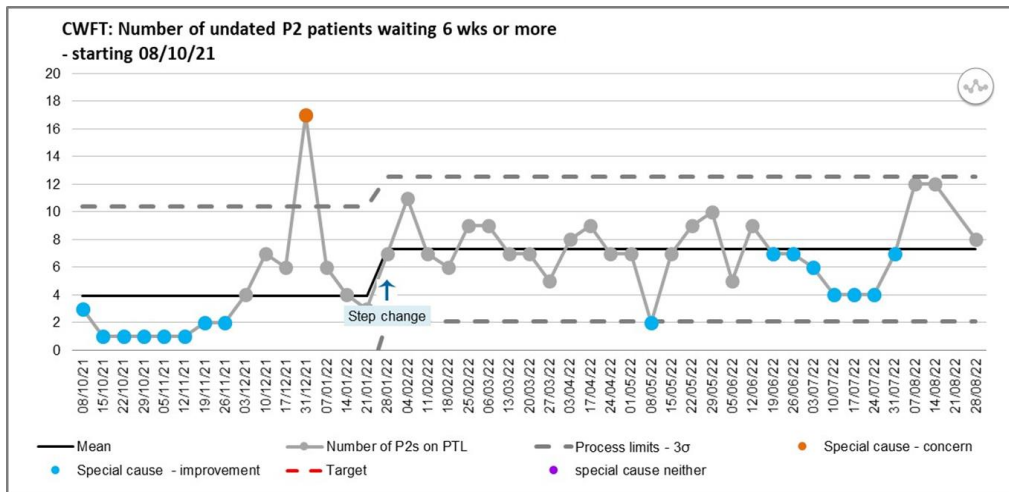


Total (dated and undated) P2 patients waiting 6 weeks or more at each Trust



Source: Exception reporting from Trusts.

Undated P2 patients waiting 6 weeks or more at each Trust



Source: Exception reporting from Trusts.

Prioritisation of admitted patients: Data source and quality

'Null' data across NWL

Dates	Total number of patients on the PTL	Nulls (n)	Nulls (%)
31/07/2022	25,858	2,912	11%
07/08/2022	25,708	2,894	11%
14/08/2022	25,611	2,763	11%
21/08/2022	25,296	2,633	10%

'Null' % by Trust

Trusts	31/07/2022	07/08/2022	14/08/2022	21/08/2022
CWFT	3%	3%	3%	3%
ICHT	18%	18%	19%	20%
LNWUHT	4%	5%	6%	3%
THHFT	17%	16%	7%	5%



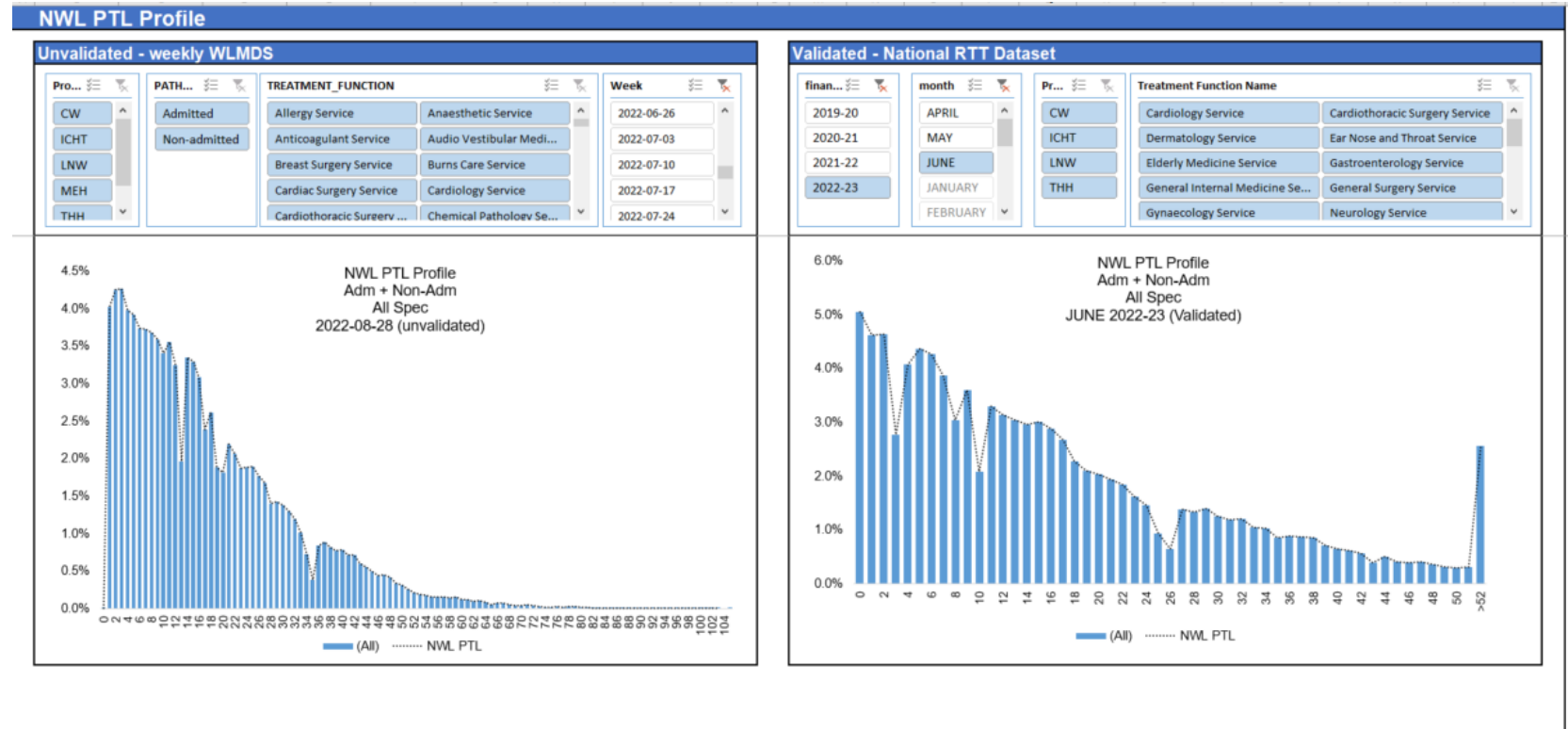
Appendix 3 – HVLC PTL Profiling

PTL Profile

- New report looking at PTL Profile available in the NWL Analytics Hub:

https://nhs.sharepoint.com/:x:/r/sites/msteams_e16666/Shared%20Documents/Elective/Elective%20Care%20Board%20docs/PTL%20Profile.xlsx?d=wa83430bcbaab4971ba3ca13f36d1ab8d&csf=1&web=1&e=uc3PUh

Copy and paste above link into web browser to access.



NW London Diagnostics Performance

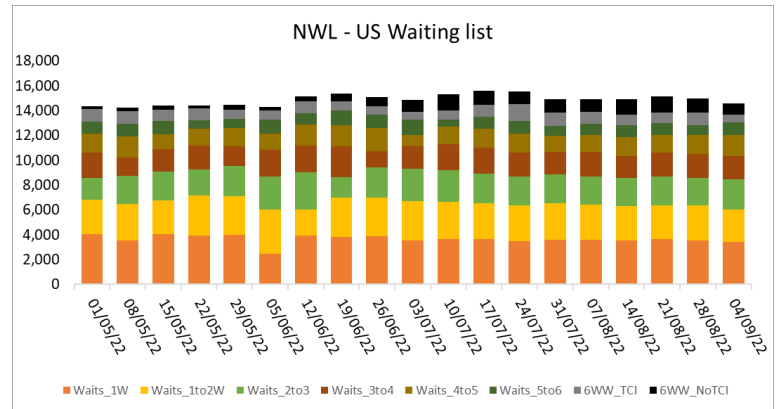
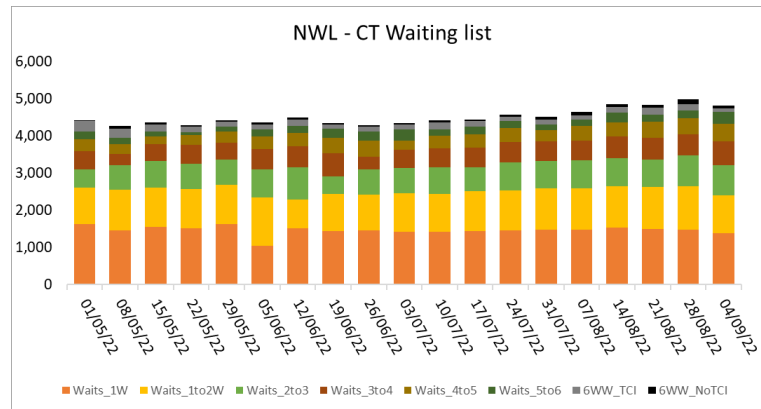
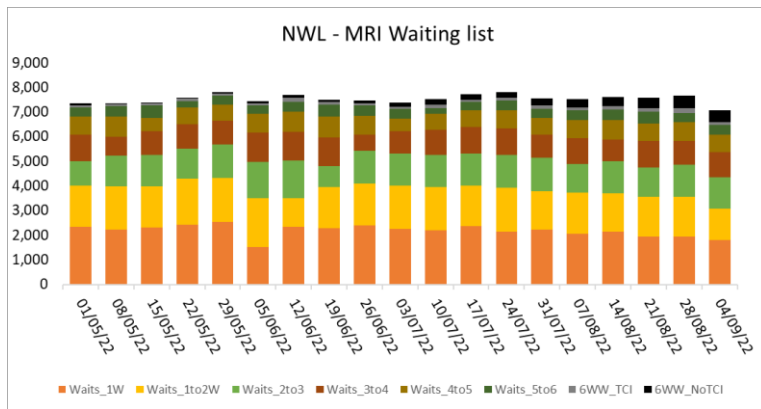
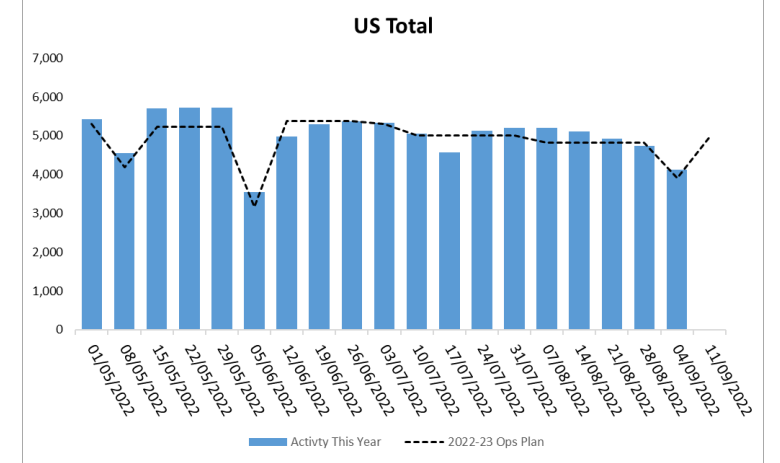
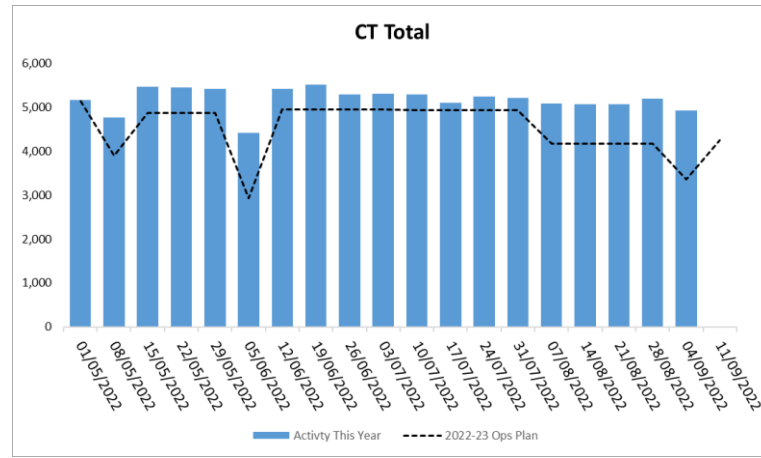
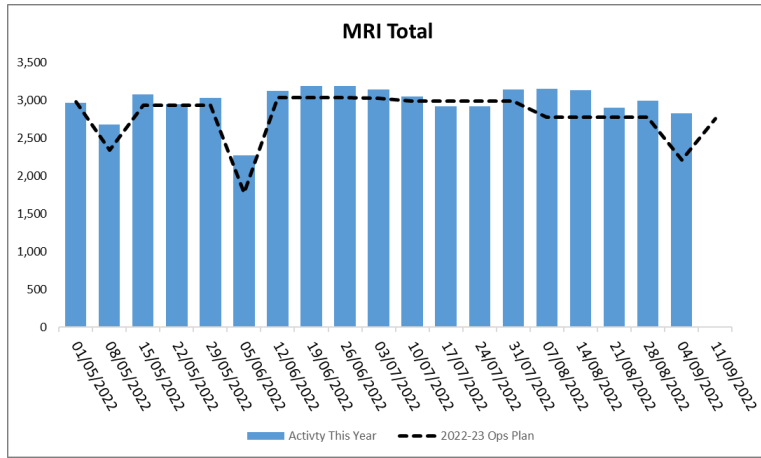
SRO – Tina Benson

AD for Diagnostics and Critical care – David Hill

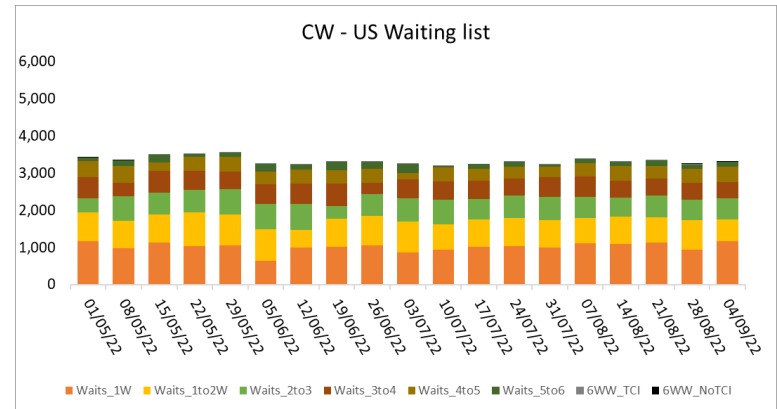
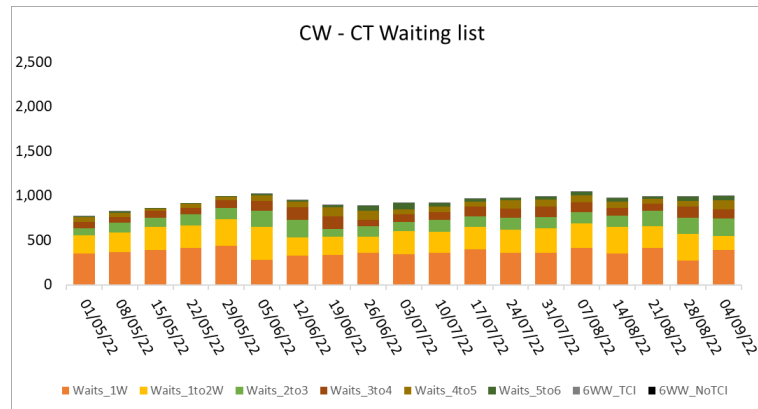
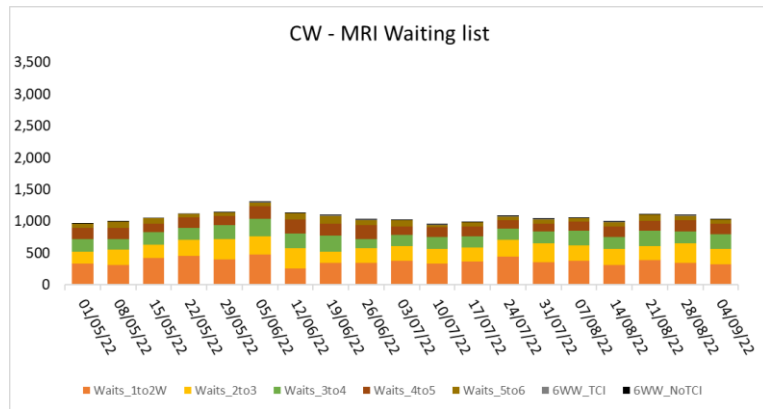
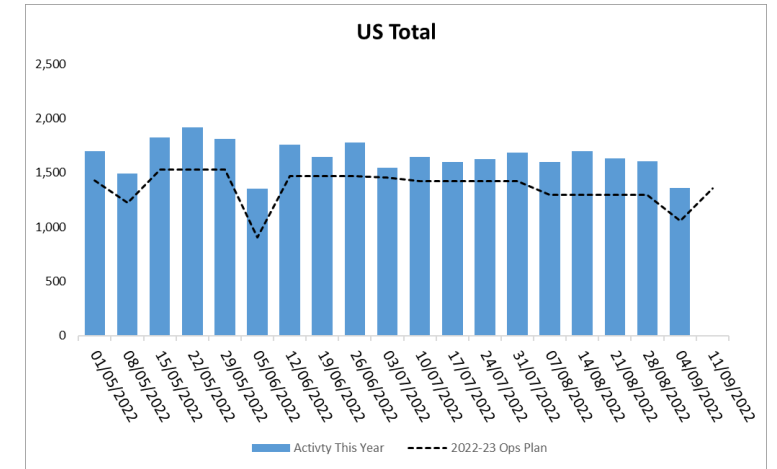
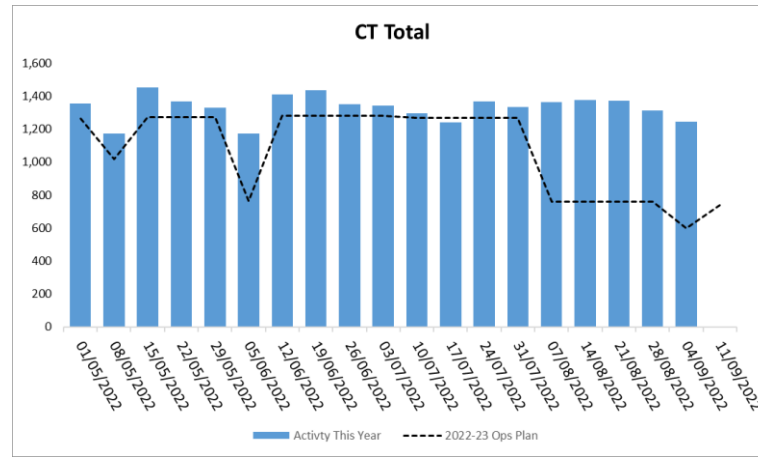
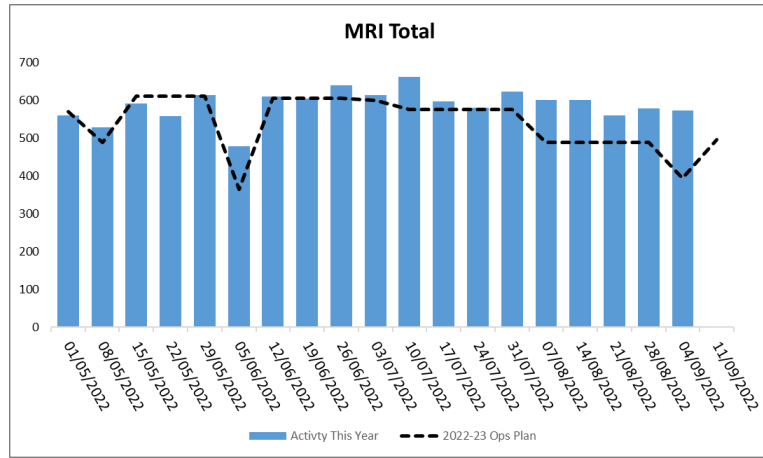
Diagnostic Action Plan

Performance Issue	Contributory Factors	Actions	Confidence RAG rating
NOUS THH: - 6 wks backlog = 1,210 - PTL size = 3,815 ICHT: - 6wks backlog = 267 - PTL size = 4,545	THH - Staff shortage ICHT - Staff shortage	Healthshare activity: - THH: 200 patients/week – w/c 8 th August Healthshare activity: - ICHT: 300 patients/week – w/c 8 th August	Amber: THH: Expect to clear backlog in 19 weeks. Amber: ICHT: expect to clear backlog by December'22. In the last week the backlog decreased with 30%.
Echo THH: - 6 wks backlog = 844 - PTL size = 1,183 ICHT: - 6 wks backlog = 393 - PTL size = 545	THH - Capacity underutilized due to lack of electronic reporting system - Admin staff shortage ICHT - Clinical staff vacancies	THH: - Investigating increase in demand and capacity shortfall - A business case is in progress for reporting system. - Discussion to use an extra small room in Echo area/Outsourcing ICHT: - Insourcing (awaiting confirmation on extension of contract)	Red: THH: Backlog continuing to increase, no clear actions to address capacity shortfall in the short term. Amber: ICHT: Plan currently being worked up to extend the insourcing contract to align with Physiologist strategy. Still clarifying if it will meet demand.
Audiology ICHT: - 6 wks backlog = 826 - PTL size = 1,623 THH: - 6 wks backlog = 176 - PTL size = 608	ICHT: - Staff shortage THH: - Staff shortage	ICHT: - Successful recruitment of 2 Band 5 and 2 Band 6 audiologists and 2 locum. Weekend clinics with external locums . THH: - Successful recruitment of 1 Band 5. Interview for 1 Band 6.	Amber ICHT: still not a full establishment although it has slightly improved from an overall shortfall of 4.3WTE to 2.5 WTE in Aug. Green: THH: New staff started started on 15 th Aug. Locum staff – part time
Endoscopy THH - 6 wks backlog = 427 - PTL size = 1,078	THH - Demand increased - Admin staff shortage - Shortfall in capacity	THH: - Deep dive in progress – awaiting time line Healthshare activity: - 50 referrals/week	Red THH: - No additional action plan except Healthshare - high rejection rates of outsource activity

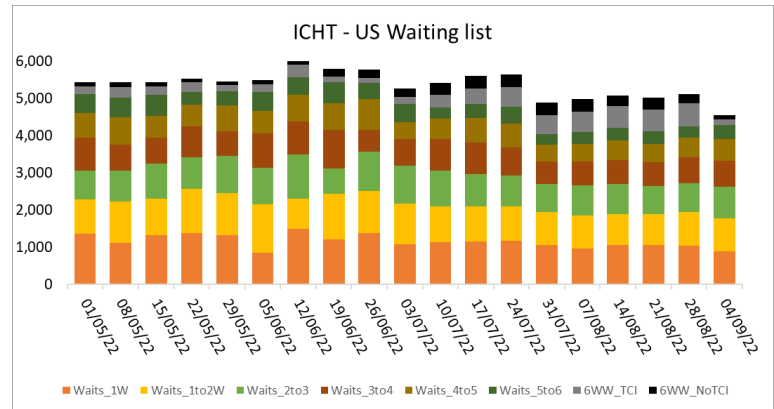
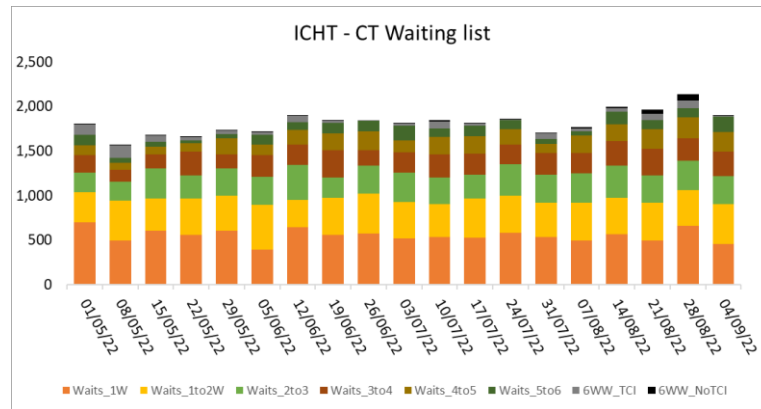
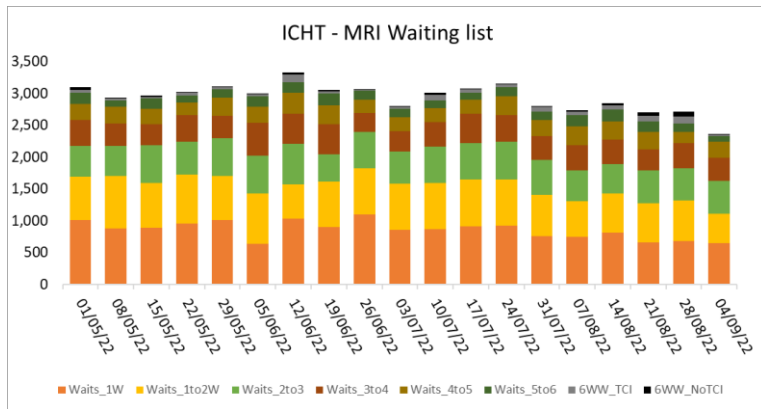
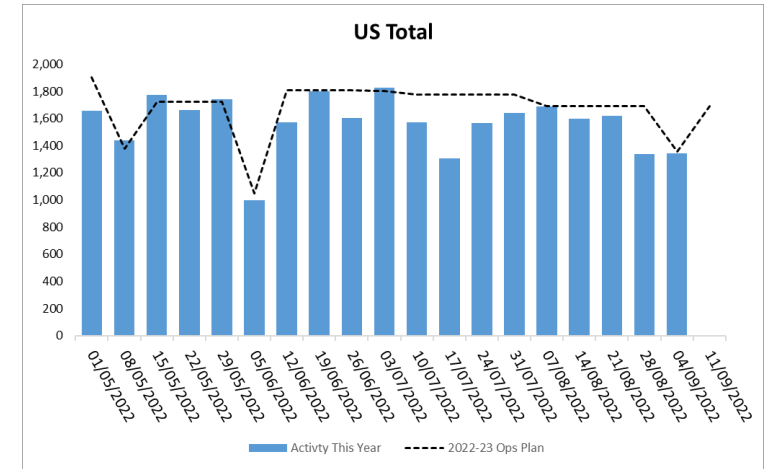
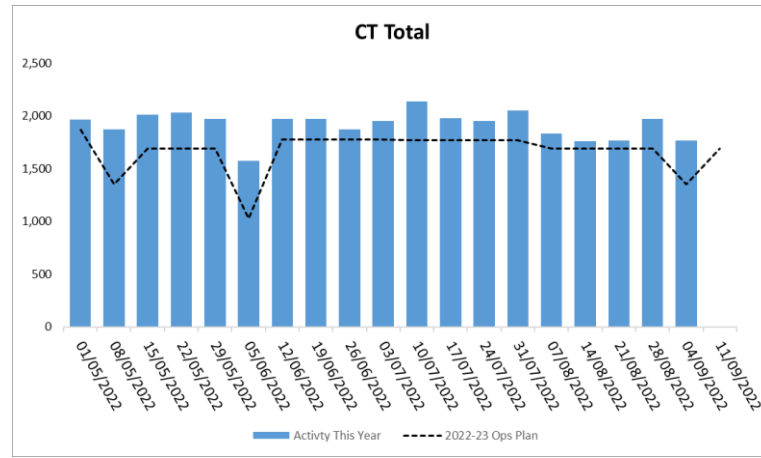
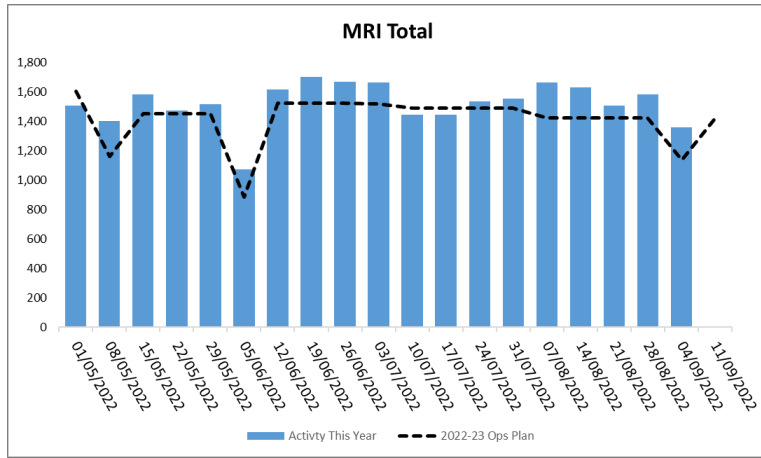
NWL imaging - performance



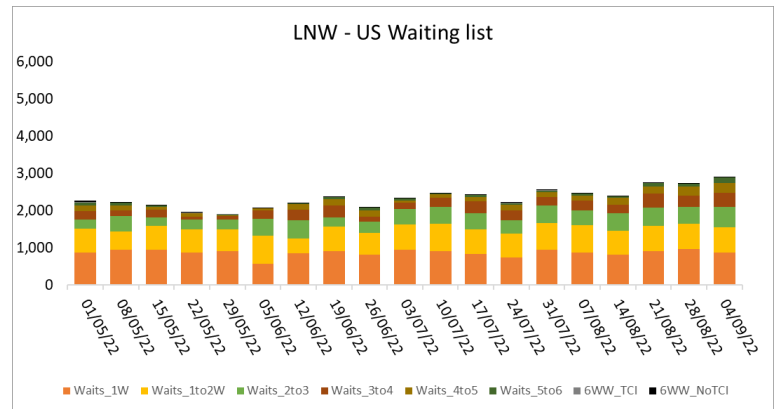
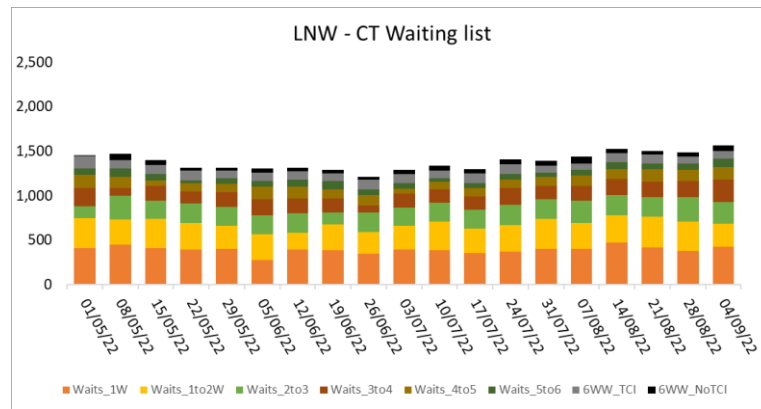
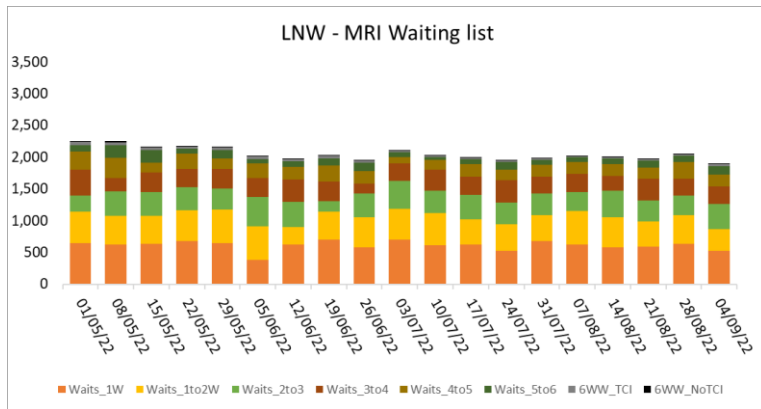
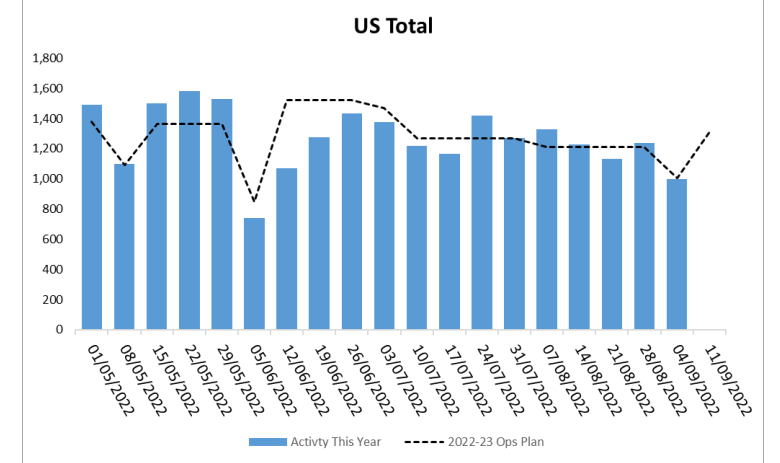
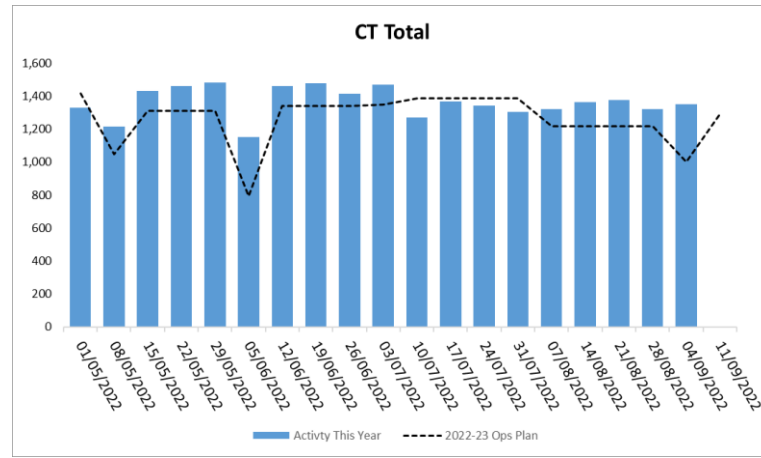
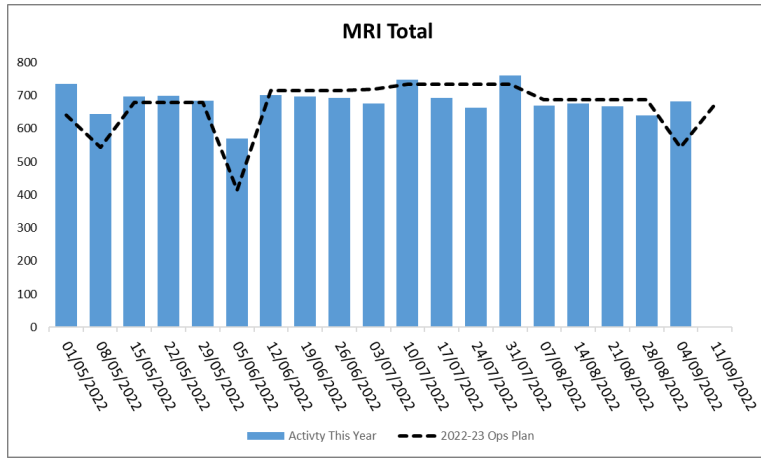
Imaging – C&W performance



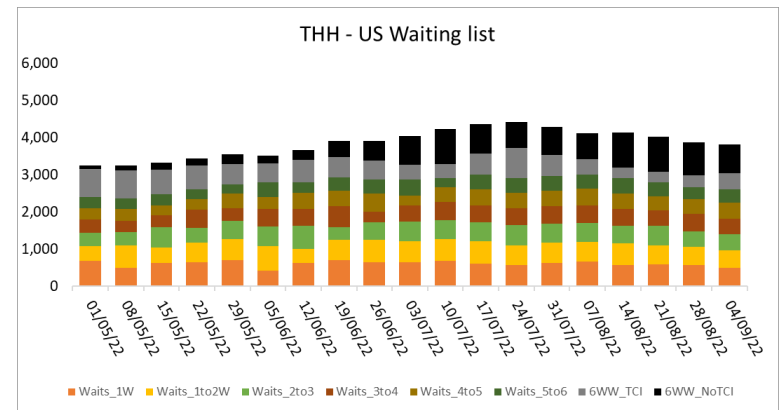
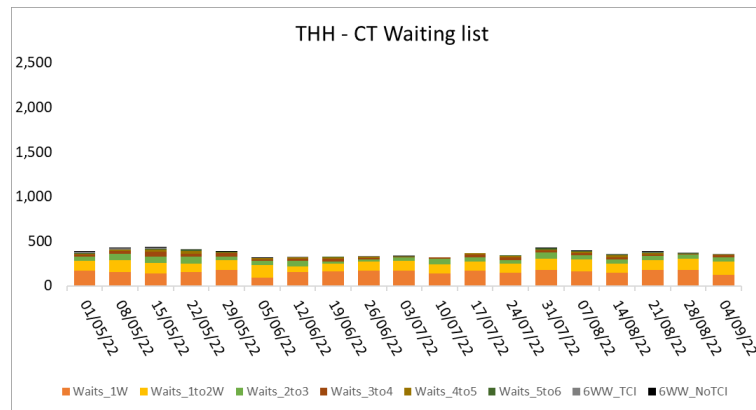
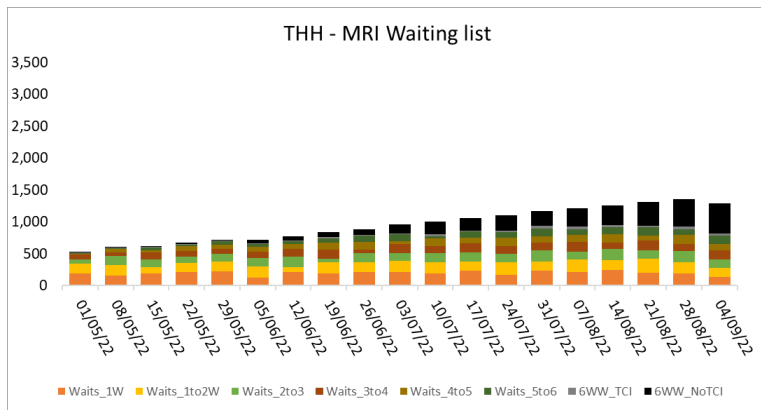
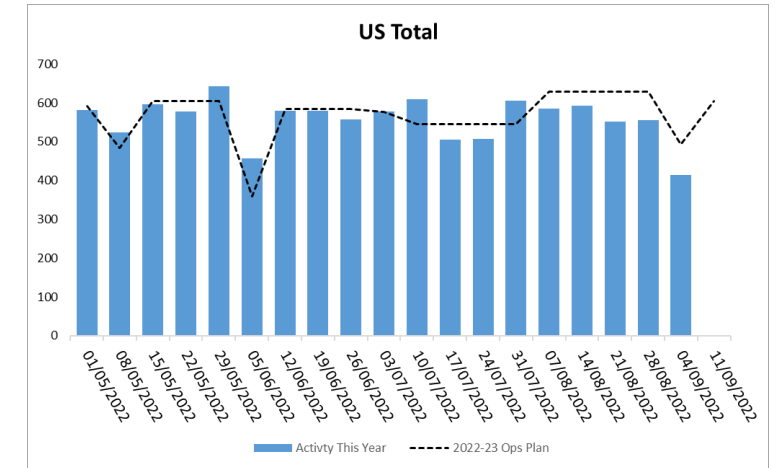
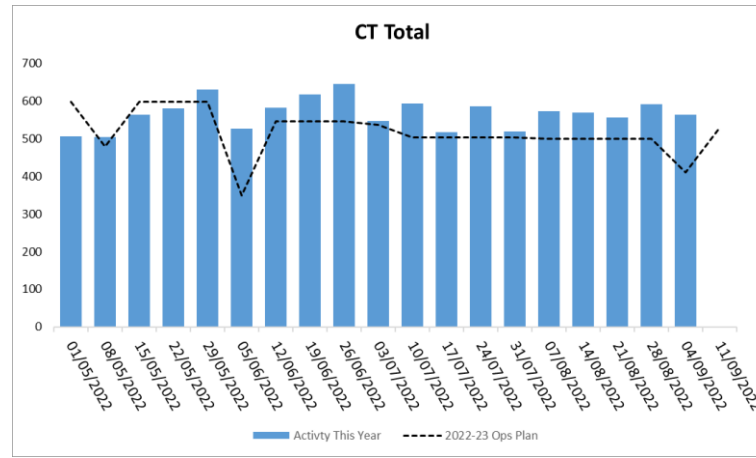
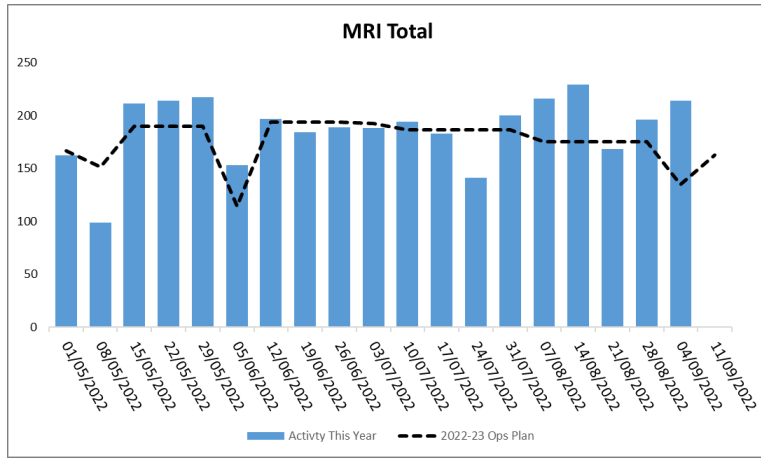
Imaging – ICHT Performance



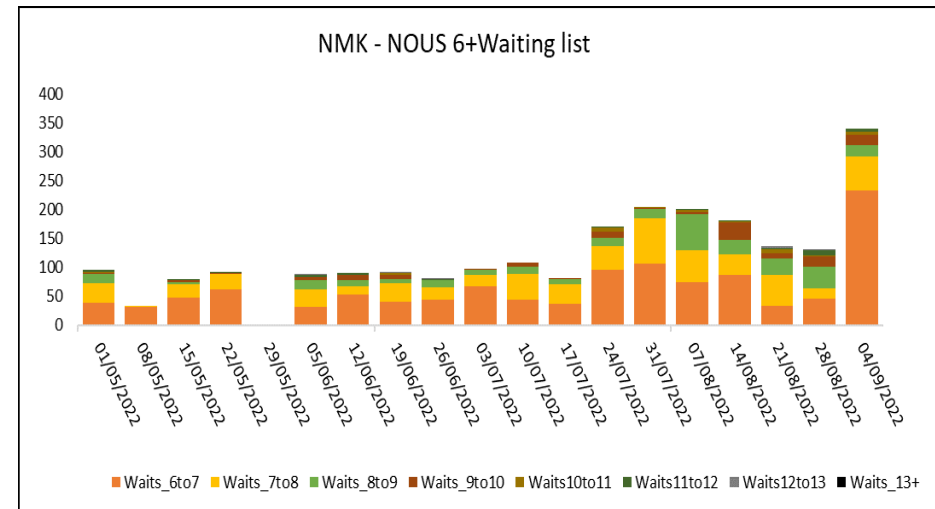
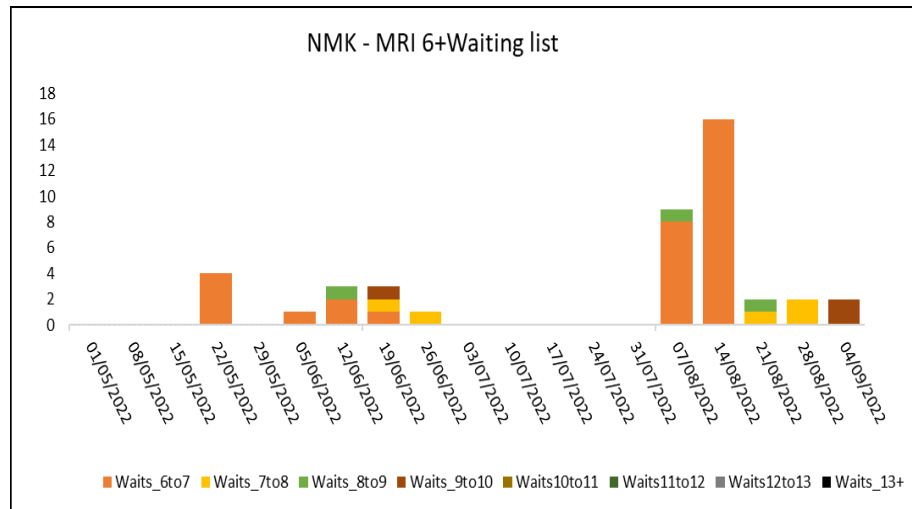
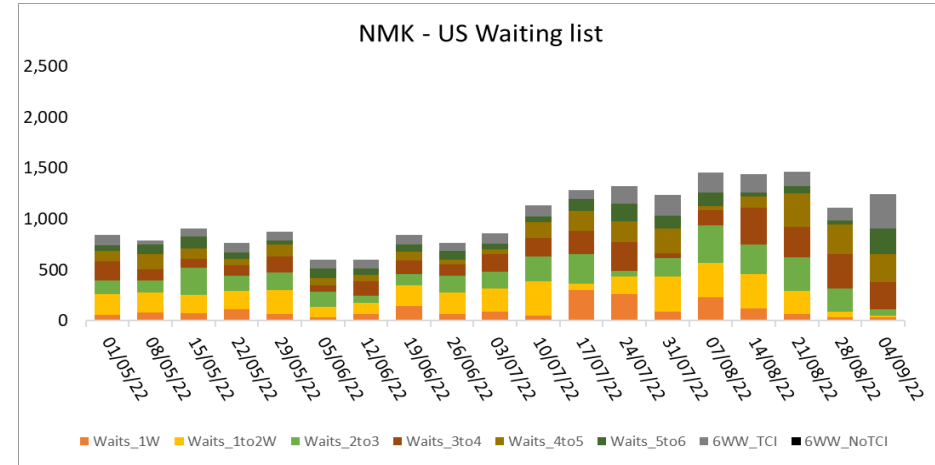
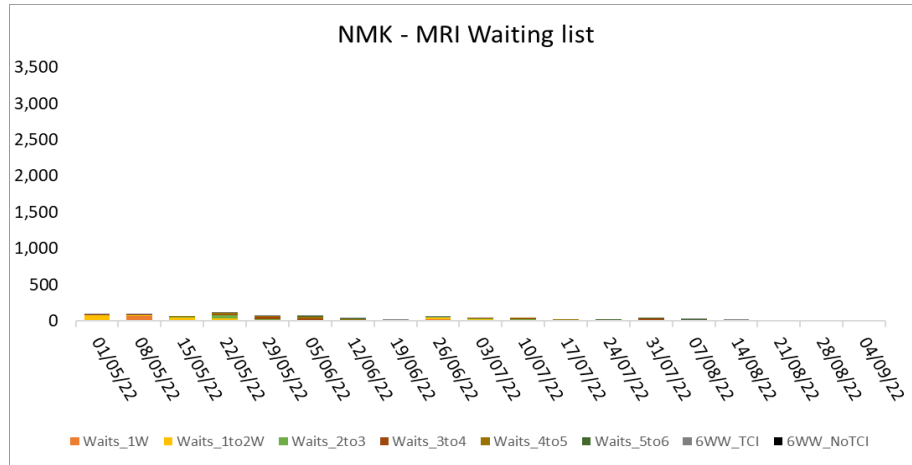
Imaging – LNW Performance



Imaging – THH Performance

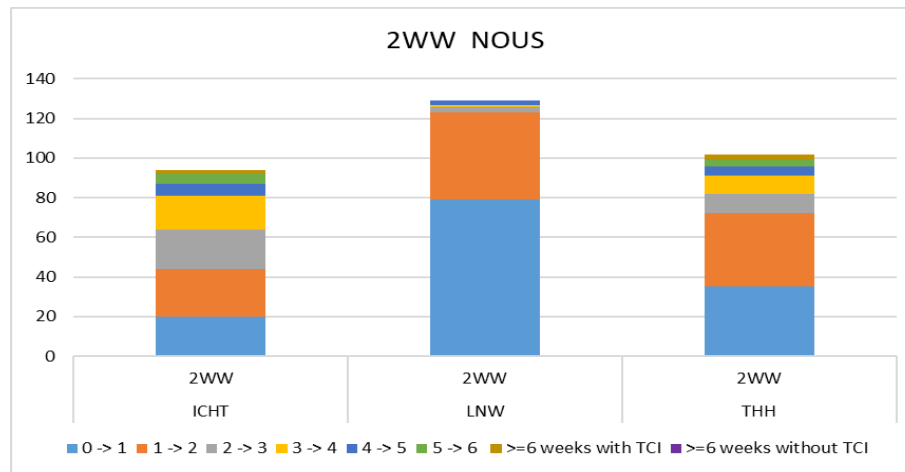
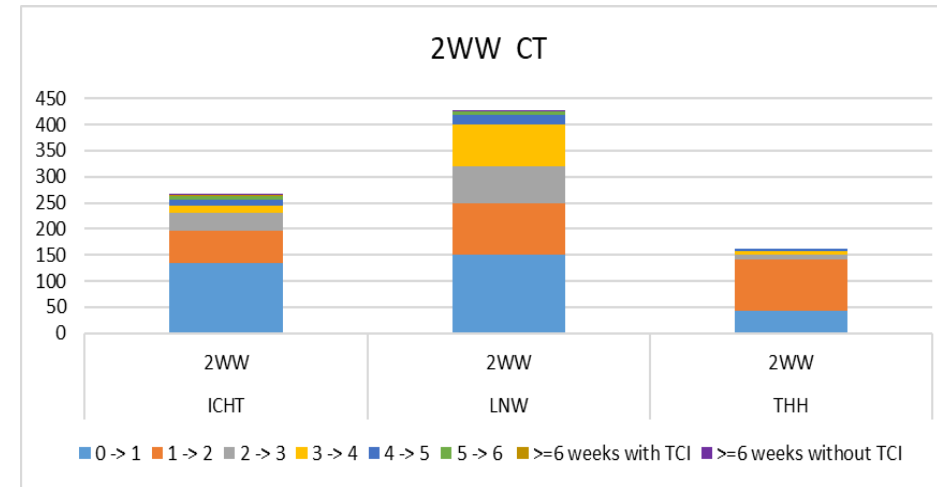
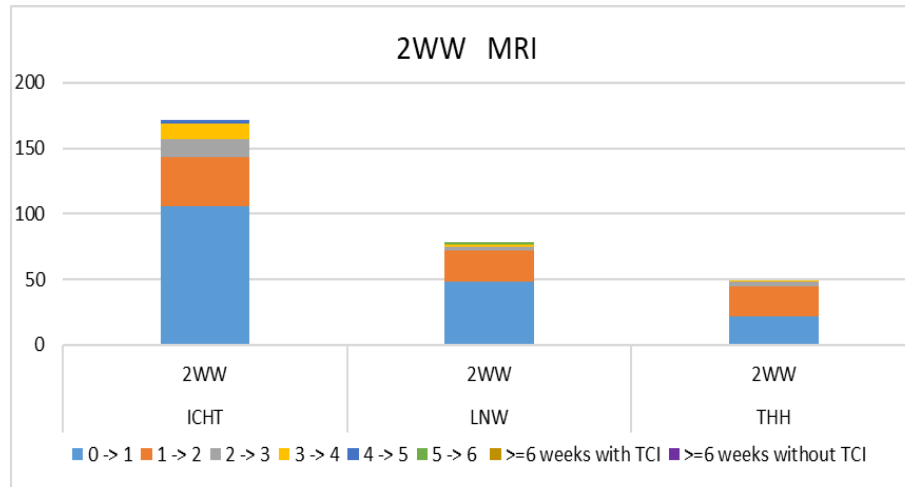


Imaging – Healthshare waiting list

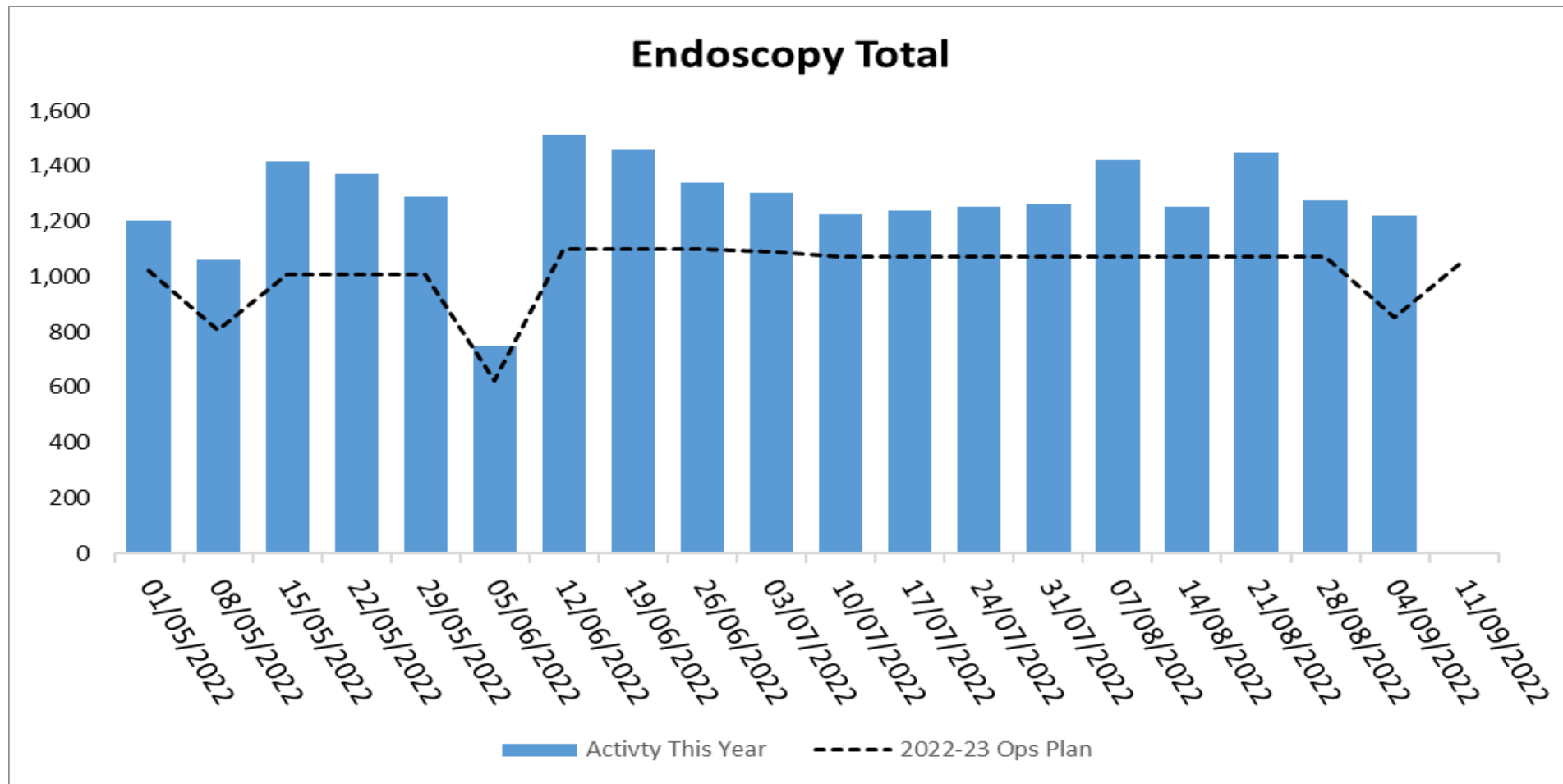


2ww waiting times for imaging (by modality)

w/e 04/09

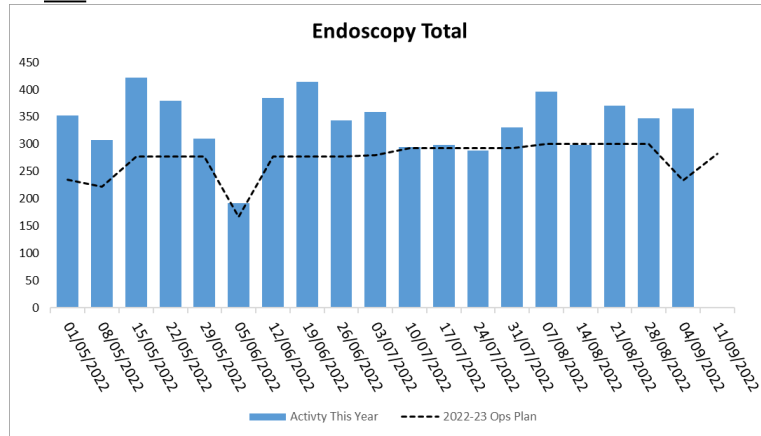


NWL Endoscopy - performance

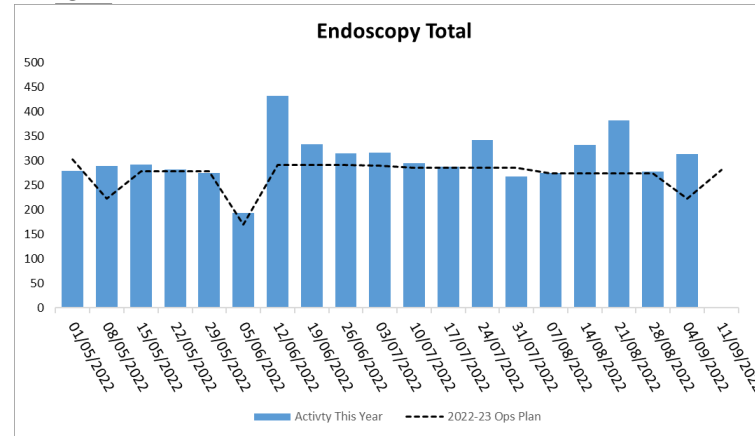


Endoscopy procedures (patients) – by Trust

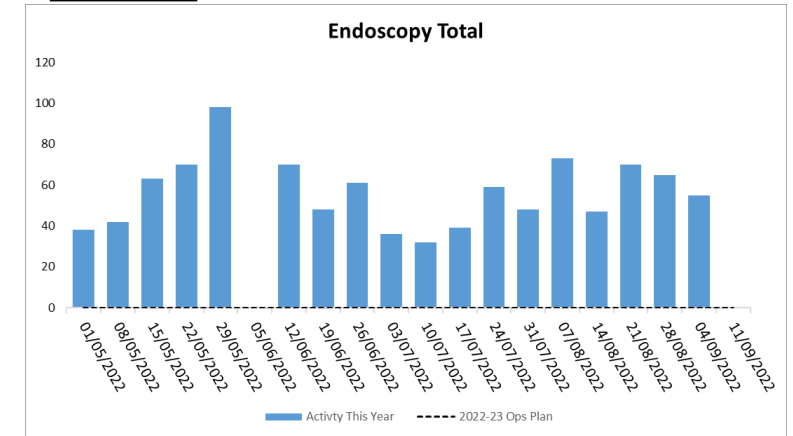
CW



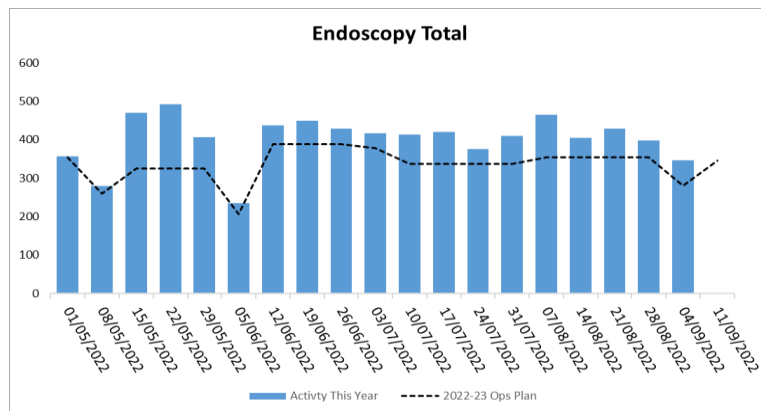
ICHT



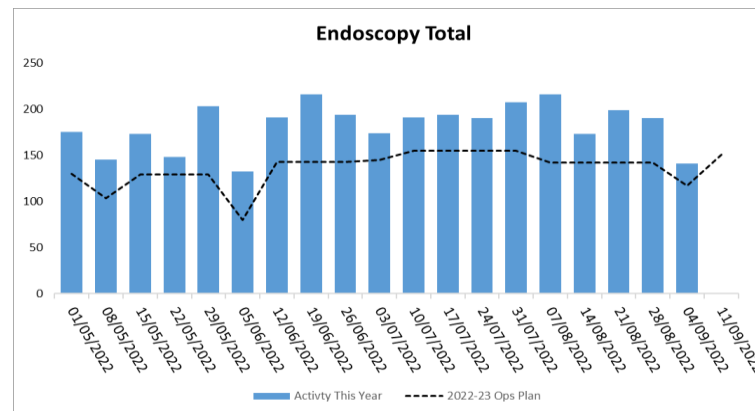
Healthshare



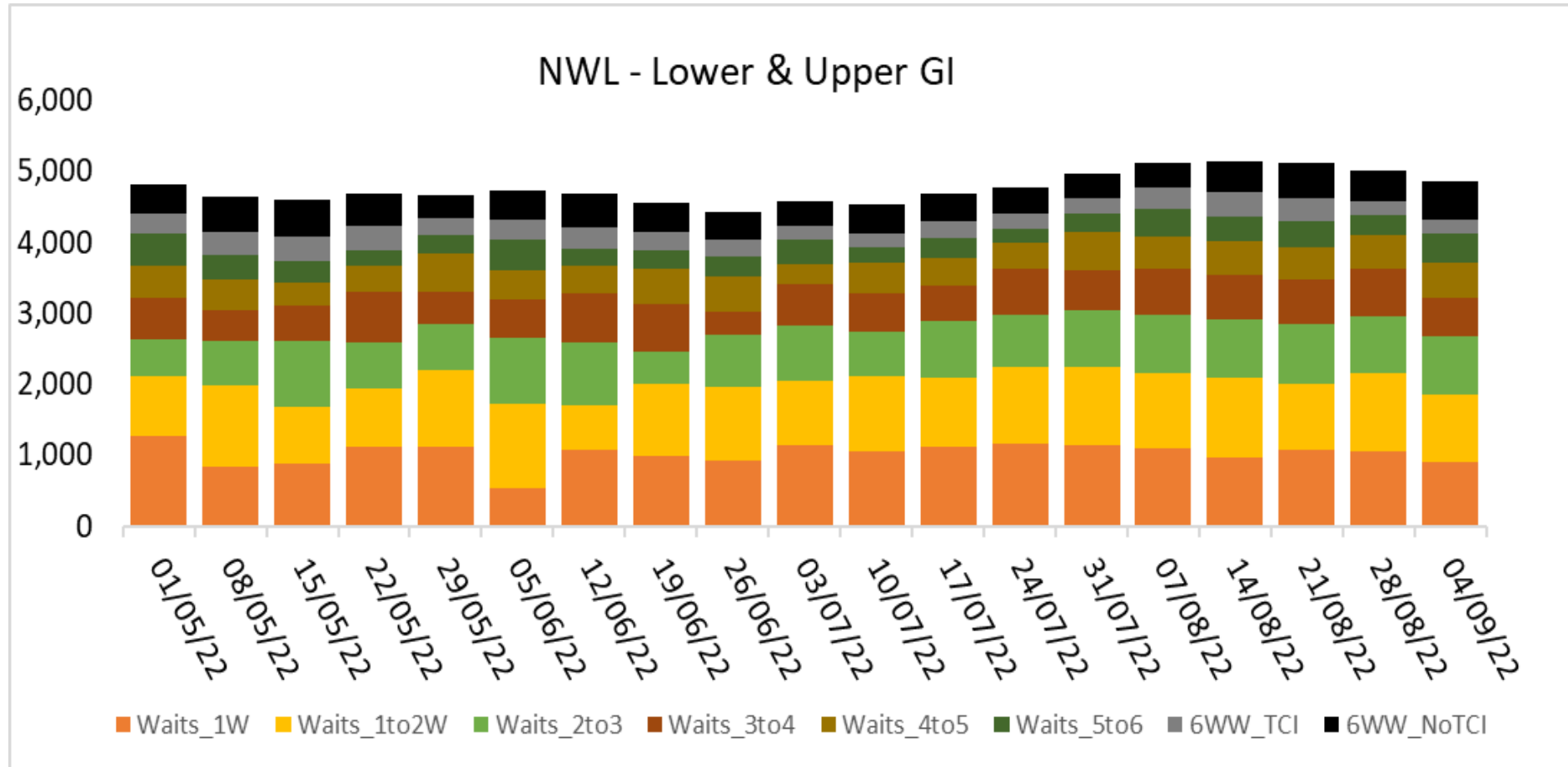
LNW



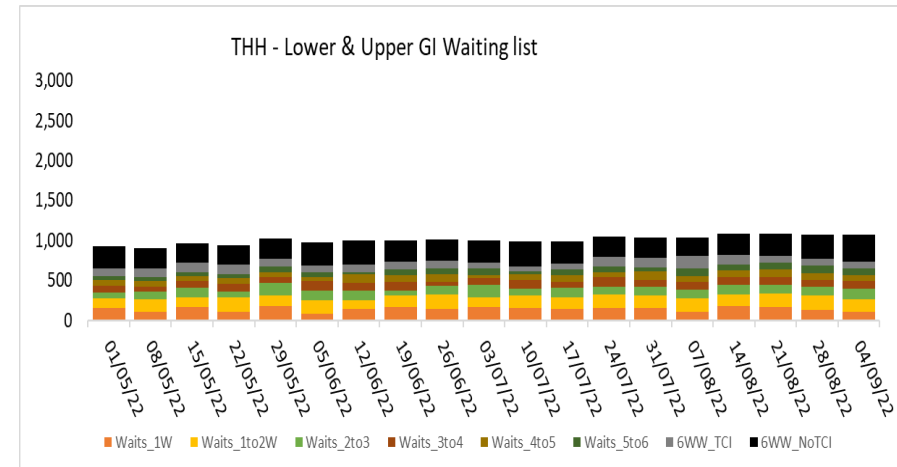
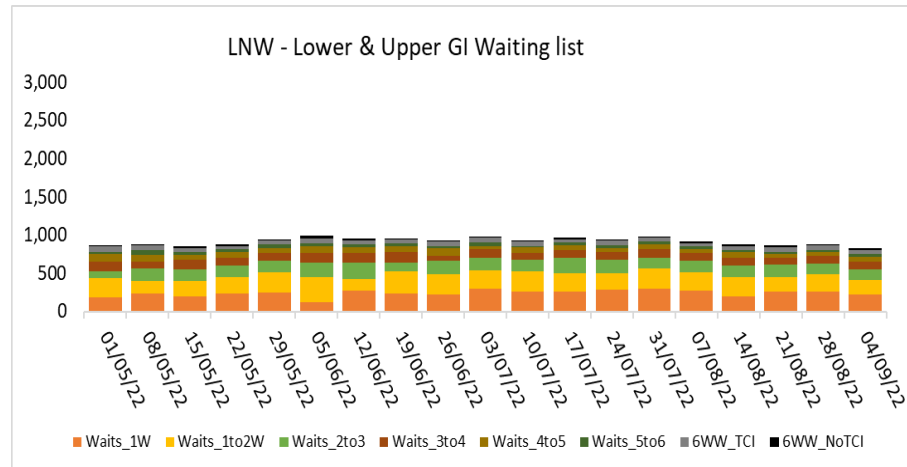
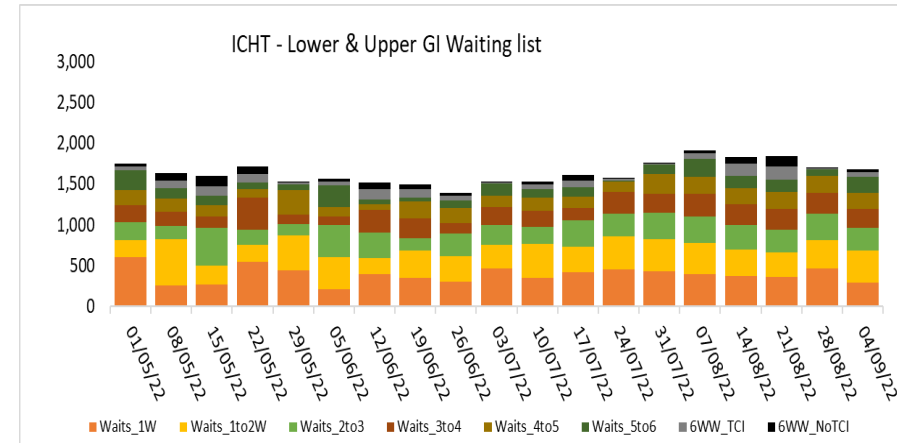
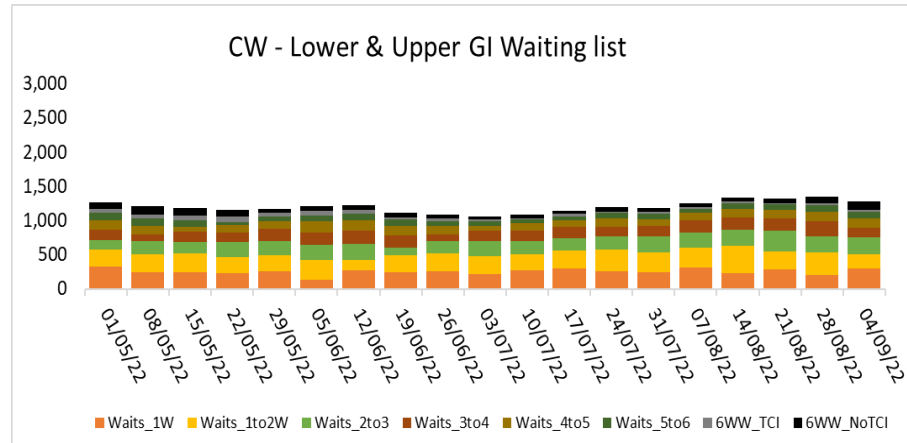
THH



Endoscopy Waiting List – NWL overall

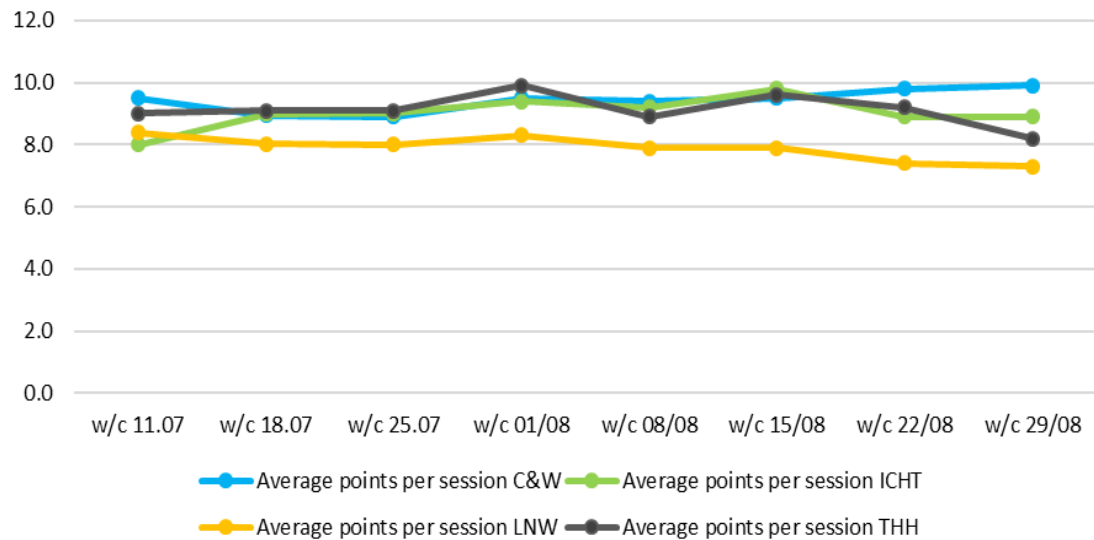


Endoscopy Waiting List – by Trust

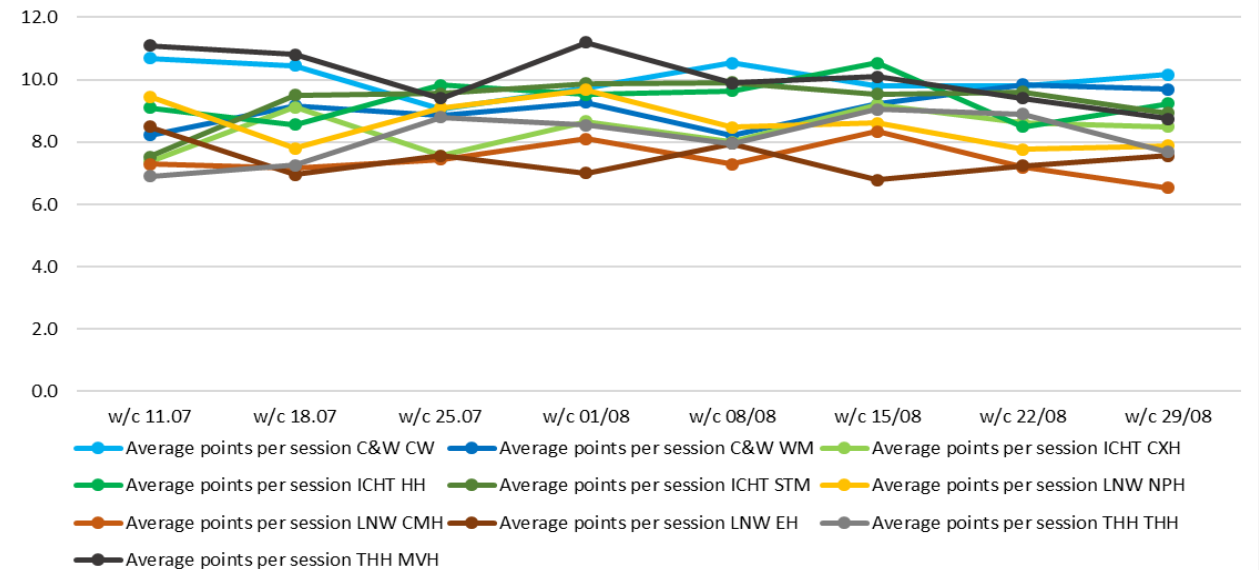


Endoscopy - Capacity utilisation points by Trust (per site) w/c 29/08

Average points per session by Trust

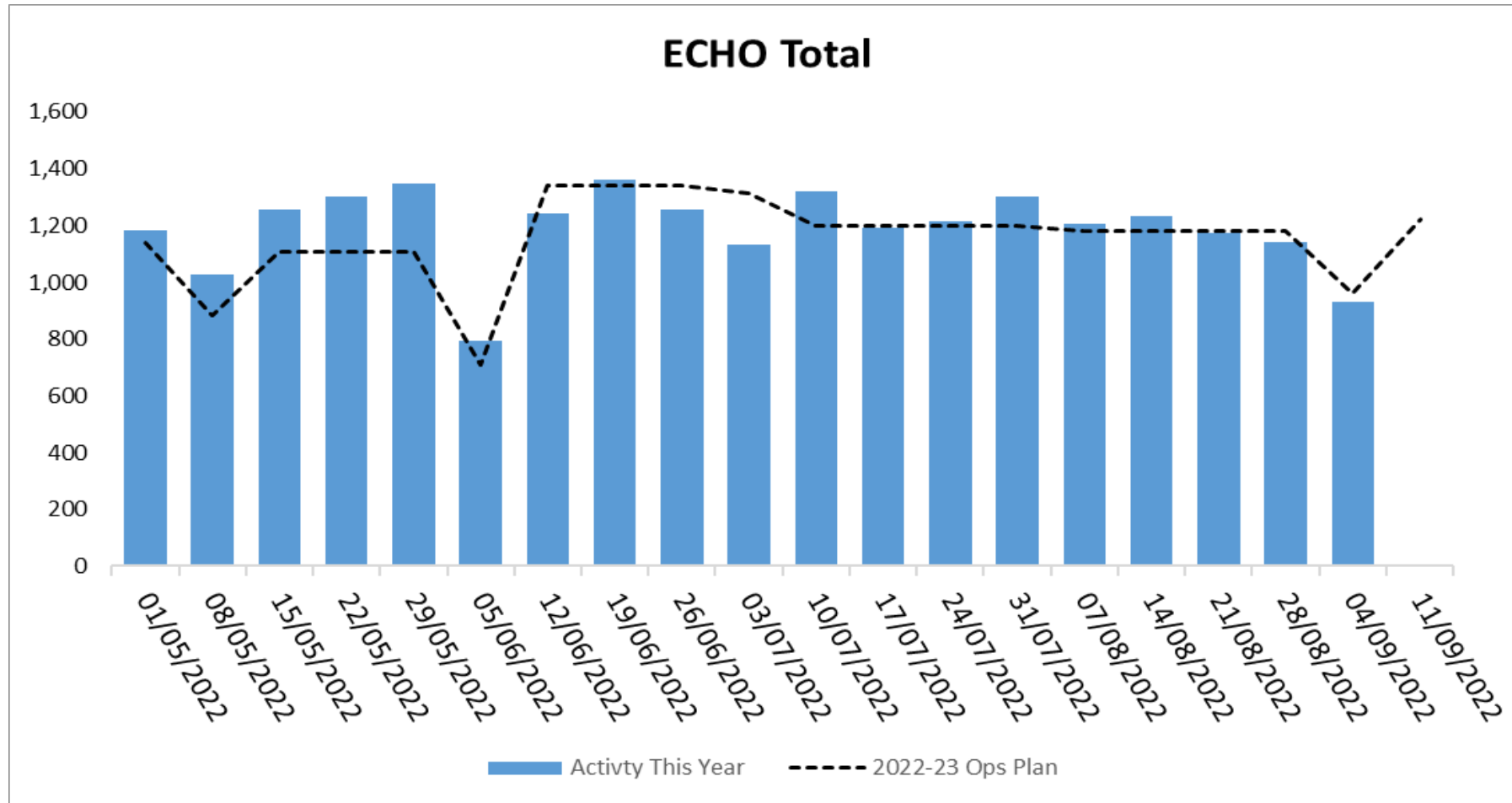


Average points per session by Site



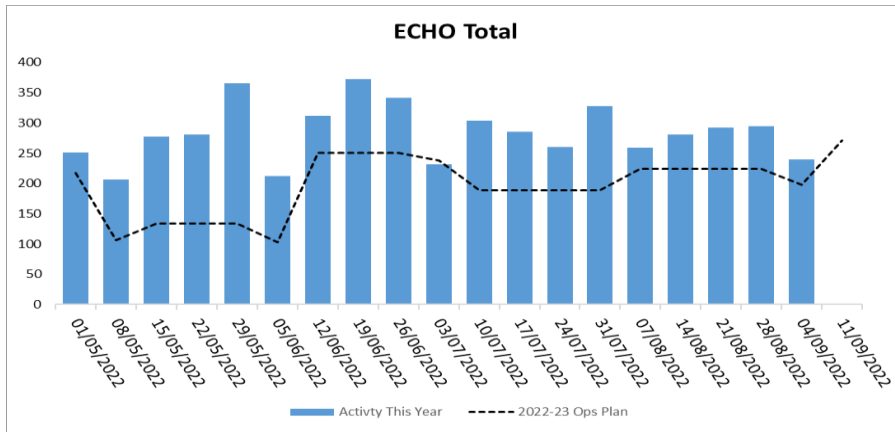
- Taken into account only the sessions from Monday to Friday
- NWL w/c 29.08 productivity: 89% utilisation sessions; 84% utilisation patients seen; 75% utilisation points
- For w/c 29.08, average patients/points per session NWL: 5.1 patients/ 8.5 points per session

NWL Echo performance

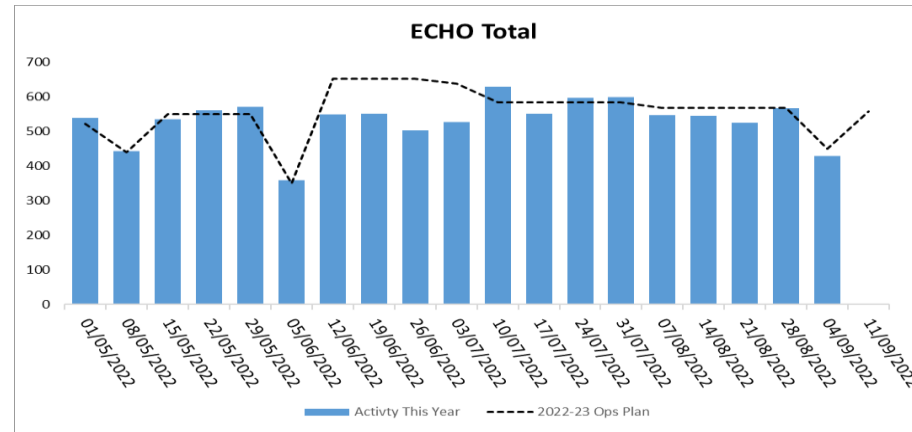


Echo procedures (patients) – by Trust

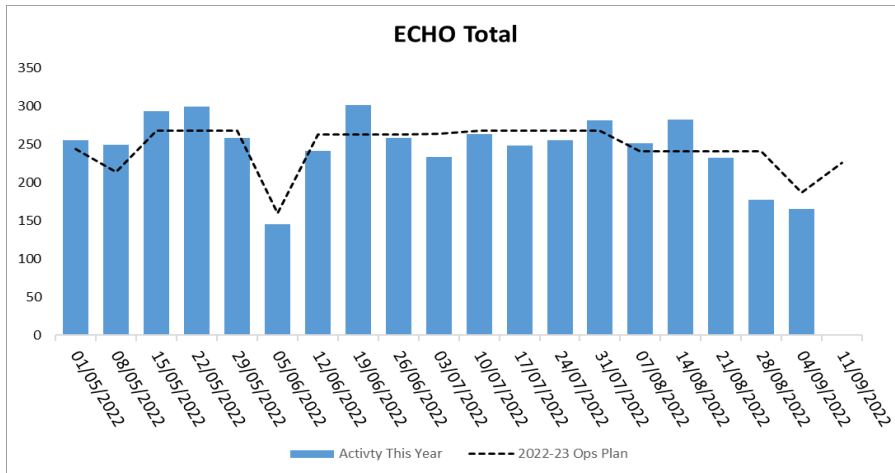
CW



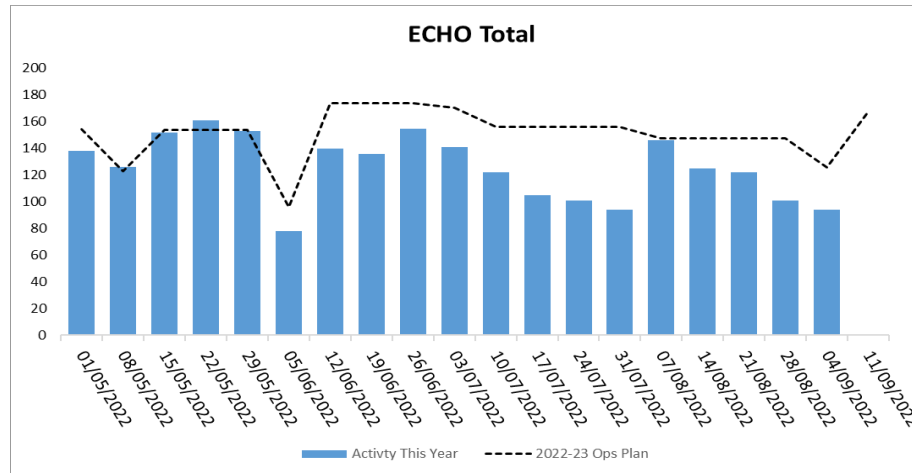
ICHT



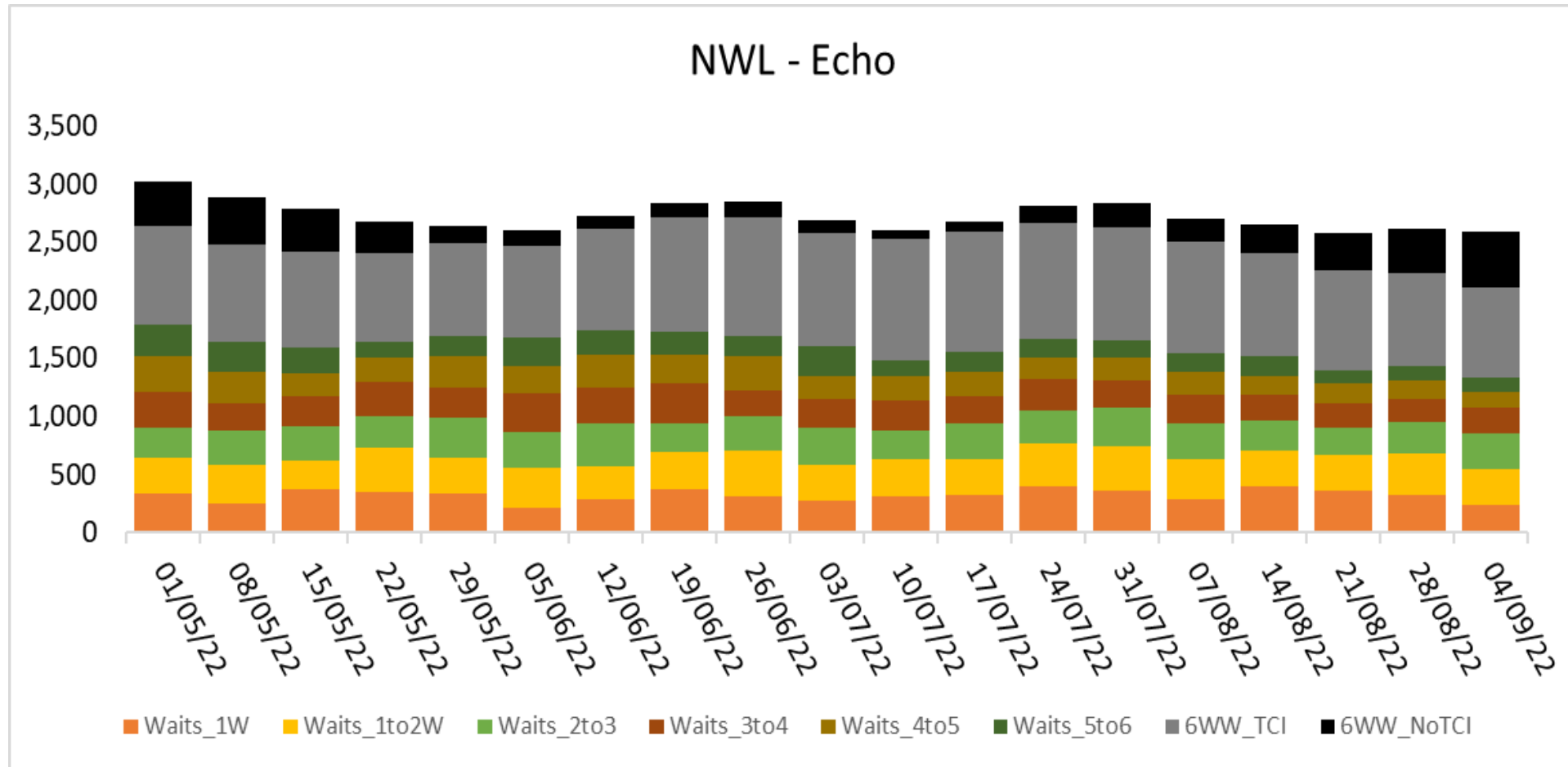
LNW



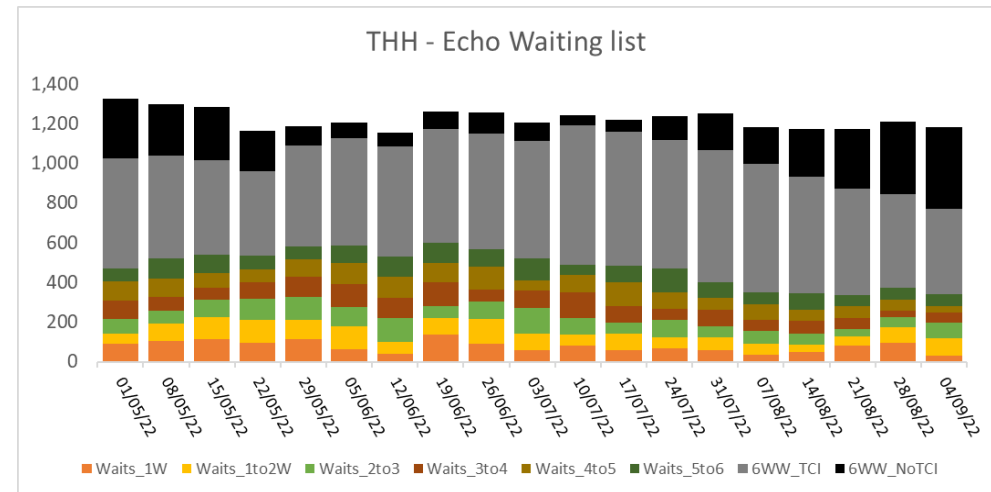
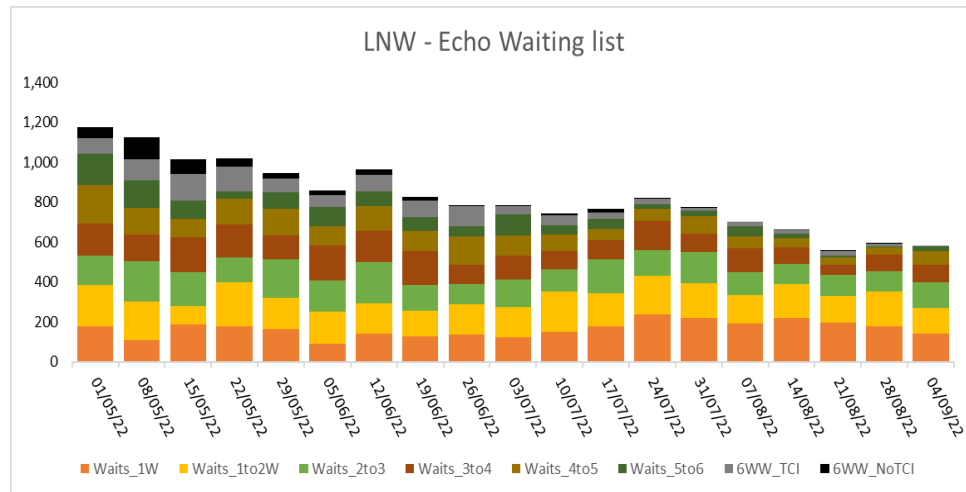
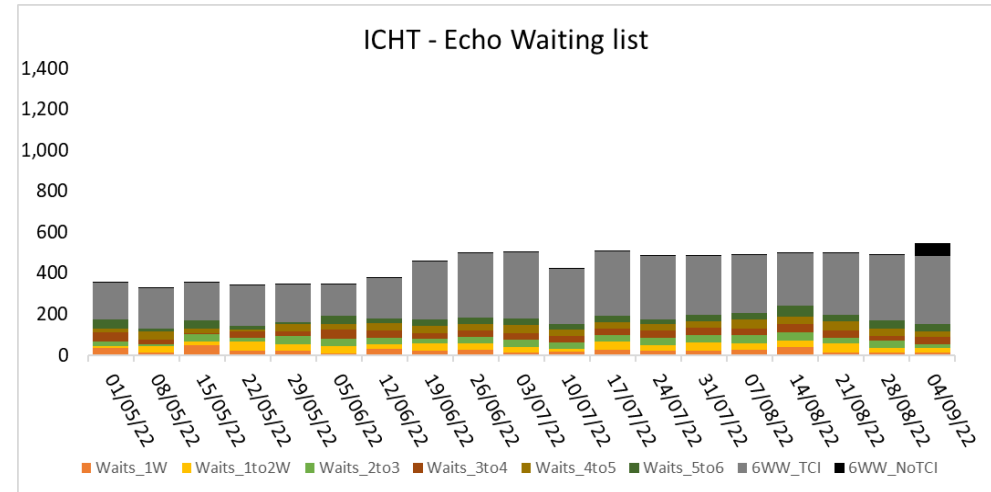
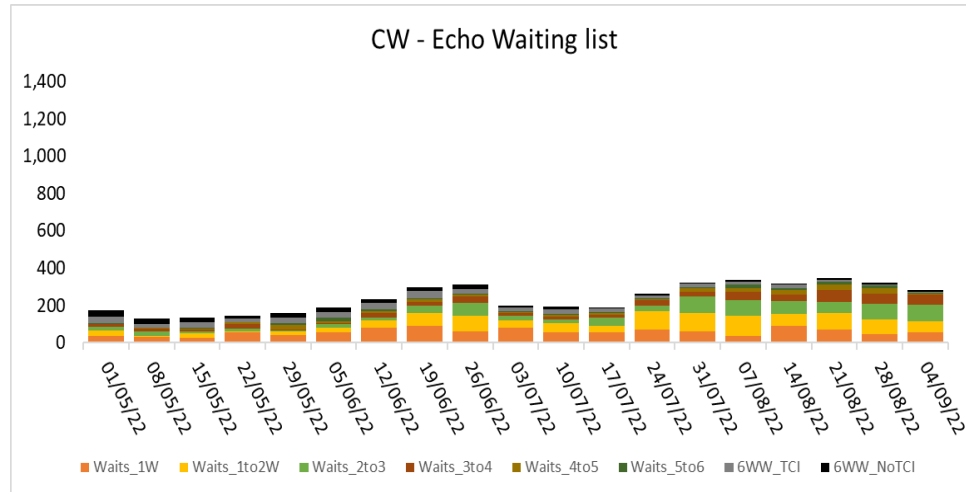
THH



Echo Waiting list – NWL overall



Echo Waiting List – by Trust



Percentage of Patients Waiting over 6weeks (by modality)

Diagnostic Waiting Times and Activity (DM01) – All Provider

	2021/22 (Validated)												2022/23								
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22		Latest week (28-08-2022)			
NWL Provider	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	Waiting List Size	>6wks	>6wks %	Waiting List Size	>6wks
AUDIOLOGY_ASSESSMENTS	44%	38%	40%	34%	42%	47%	36%	40%	43%	51%	40%	41%	45%	44%	40%	43%	2,228	968	24%	740	180
BARIUM_ENEMA	32%	28%	25%	32%	43%	33%	26%	24%	21%	17%	6%	4%	2%	2%	4%	2%	210	4	6%	94	6
COLONOSCOPY	21%	14%	13%	14%	10%	10%	13%	13%	14%	13%	9%	9%	10%	8%	10%	9%	2,176	198	11%	2,406	272
CT	4%	2%	1%	1%	1%	1%	3%	6%	13%	11%	5%	4%	5%	4%	4%	4%	4,059	155	6%	4,983	290
CYSTOSCOPY	37%	42%	46%	44%	39%	44%	46%	48%	33%	34%	34%	42%	40%	35%	30%	23%	632	146	25%	445	112
DEXA_SCAN	0%	0%	1%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	4%	1,071	38	7%	1,144	76
ECHOCARDIOGRAPHY	7%	9%	9%	7%	10%	14%	11%	13%	24%	28%	23%	31%	34%	28%	34%	36%	2,884	1045	45%	2,621	1,188
ELECTROPHYSIOLOGY	21%	22%	25%	17%	11%	13%	5%	11%	0%	0%	0%	9%	25%	15%	29%	32%	41	13	61%	38	23
FLEXI_SIGMOIDOSCOPY	37%	40%	36%	21%	27%	26%	21%	14%	16%	16%	14%	13%	12%	12%	11%	10%	538	52	13%	573	77
GASTROSCOPY	35%	31%	26%	21%	20%	20%	17%	17%	17%	19%	14%	12%	12%	11%	11%	11%	1,924	220	14%	2,031	278
MRI	4%	7%	10%	14%	18%	15%	14%	6%	5%	4%	2%	2%	1%	1%	3%	6%	6,430	356	9%	7,664	700
NON Obstetric Ultrasound	4%	7%	6%	6%	5%	2%	2%	3%	3%	4%	3%	5%	8%	6%	11%	13%	14,739	1892	14%	14,957	2,122
PERIPHERAL NEUROPHYS	82%	80%	84%	87%	73%	72%	63%	59%	55%	25%	5%	4%	2%	1%	0%	0%	896	2	13%	542	73
SLEEP STUDIES	3%	1%	0%	1%	1%	3%	3%	8%	13%	13%	6%	4%	4%	4%	1%	2%	277	6	28%	323	89
URODYNAMICS	59%	60%	49%	52%	55%	58%	43%	55%	52%	48%	38%	41%	21%	17%	16%	13%	150	20	44%	118	52
NWL	19%	20%	20%	19%	18%	16%	14%	13%	15%	14%	9%	11%	12%	10%	12%	13%	38,255	5,115	14%	38,679	5,538

RAG Rating
<5%
5-10%
>10%

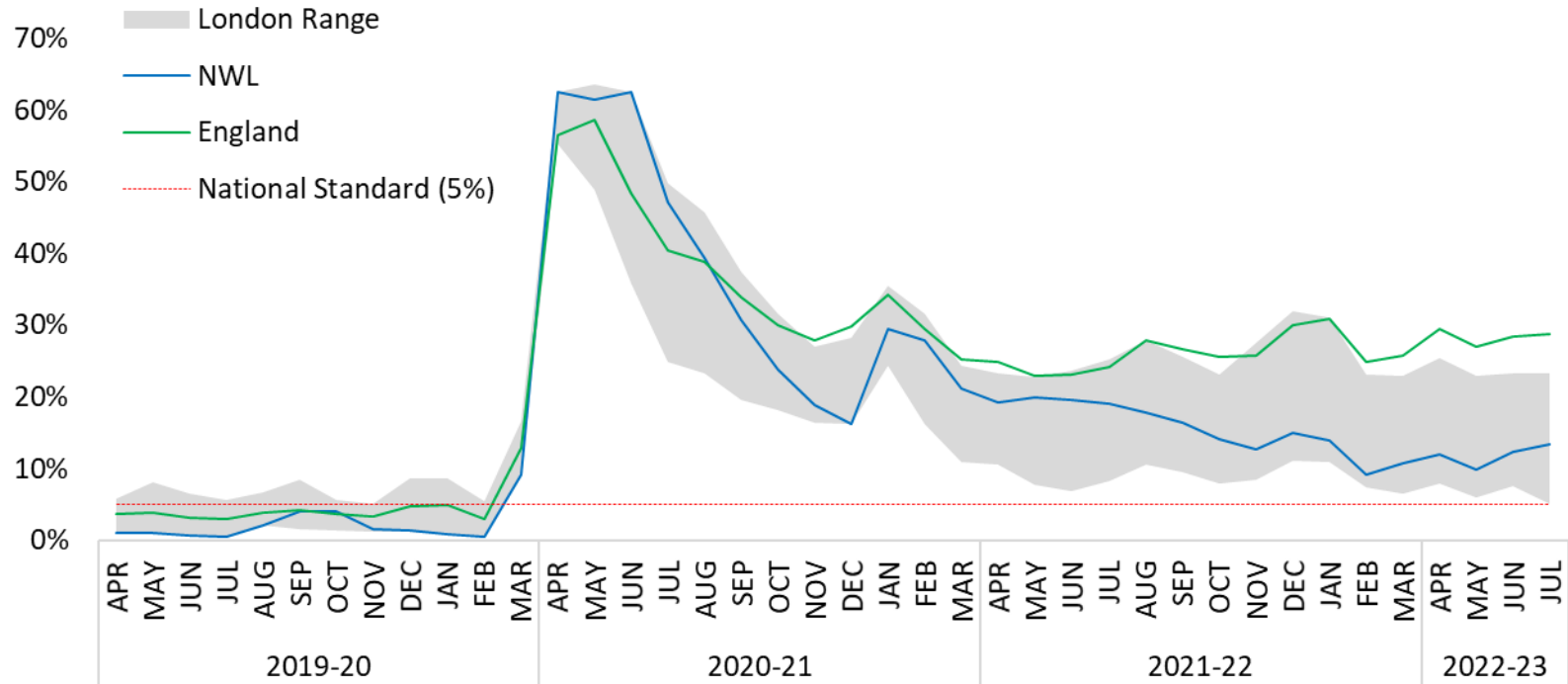
Please note we are clarifying with NHSE the change from 1% to 5% of the national target for Diagnostic Waiting Times within 6 weeks, specified in: [Delivery Plan for Tackling the COV-19 Backlog of Elective Care](#)

Aggregate DM01 trend

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: All Modalities



Percentage of Patients Waiting over 6weeks (by modality)

Diagnostic Waiting Times and Activity (DM01) – CWFT

	2021/22 (Validated)												2022/23								
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22		Latest week (28-08-2022)			
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	Waiting List Size	>6wks	>6wks %	Waiting List Size	>6wks
AUDIOLOGY_ASSESSMENTS	0%	0%	0%	0%	0%	0%	2%	0%	1%	9%	0%	0%	0%	1%	3%	1%	134	2	7%	123	9
BARIUM_ENEMA	0%	0%	0%	0%	4%	0%	0%	0%	0%	4%	0%	3%	0%	0%	0%	0%	88	0	3%	62	2
COLONOSCOPY	3%	2%	2%	2%	3%	2%	1%	1%	1%	1%	1%	2%	3%	2%	1%	1%	470	4	11%	627	72
CT	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	932	0	1%	991	5
CYSTOSCOPY	34%	44%	48%	39%	14%	12%	7%	10%	3%	7%	5%	30%	27%	20%	11%	14%	310	44	11%	169	19
DEXA_SCAN	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	449	0	3%	538	15
ECHOCARDIOGRAPHY	12%	8%	4%	2%	5%	4%	9%	7%	7%	7%	4%	4%	2%	4%	1%	0%	483	1	4%	323	14
ELECTROPHYSIOLOGY																	0	0		0	0
FLEXI_SIGMOIDOSCOPY	3%	4%	1%	1%	2%	0%	0%	2%	0%	0%	2%	4%	6%	5%	5%	4%	144	6	10%	176	17
GASTROSCOPY	10%	9%	3%	1%	5%	3%	0%	1%	0%	1%	1%	2%	3%	3%	1%	1%	424	5	6%	548	35
MRI	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1,421	2	1%	1,545	17
NON_OBSTETRIC_ULTRASOUND	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2,936	0	1%	3,246	22
PERIPHERAL_NEUROPHYS	13%	5%	8%	9%	7%	16%	12%	3%	0%	0%	0%	9%	22%	11%	0%	6%	35	2	9%	67	6
SLEEP_STUDIES	15%	5%	0%	6%	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	5%	2%	57	1	36%	66	24
URODYNAMICS	65%	63%	61%	49%	29%	42%	14%	0%	10%	28%	11%	20%	32%	48%	45%	50%	12	6	50%	20	10
CWFT	5%	4%	3%	3%	2%	2%	1%	1%	1%	1%	1%	2%	2%	2%	1%	1%	7,895	73	3%	8,501	267

RAG Rating
<5%
5-10%
>10%

Please note we are clarifying with NHSE the change from 1% to 5% of the national target for Diagnostic Waiting Times within 6 weeks, specified in: [Delivery Plan for Tackling the COV-19 Backlog of Elective Care](#)

Percentage of Patients Waiting over 6weeks (by modality)

Diagnostic Waiting Times and Activity (DM01) - ICHT

	2021/22 (Validated)												2022/23								
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22		Latest week (28-08-2022)			
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	Waiting List Size	>6wks	>6wks %	Waiting List Size	>6wks
AUDIOLOGY_ASSESSMENTS	58%	53%	53%	43%	52%	61%	50%	57%	55%	59%	50%	51%	54%	55%	51%	56%	1,498	839	Not available		
BARIUM_ENEMA	1%	2%	1%	0%	0%	0%	0%	0%	0%	0%	2%	1%	1%	1%	4%	1%	82	1	Not available		
COLONOSCOPY	50%	81%	83%	14%	0%	11%	19%	16%	17%	12%	5%	2%	0%	1%	1%	0%	758	0	1%	852	9
CT	8%	6%	3%	2%	1%	1%	0%	0%	1%	2%	1%	3%	2%	2%	1%	2%	1,307	29	7%	2,138	157
CYSTOSCOPY	41%	44%	49%	53%	52%	59%	54%	55%	41%	42%	52%	53%	51%	44%	61%	40%	126	51	32%	65	21
DEXA_SCAN	0%	0%	3%	0%	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	2%	11%	357	38	18%	333	61
ECHOCARDIOGRAPHY	11%	11%	11%	11%	8%	11%	11%	6%	26%	40%	26%	34%	39%	43%	57%	46%	411	190	66%	494	324
ELECTROPHYSIOLOGY	21%	22%	25%	17%	11%	13%	5%	11%	0%	0%	0%	9%	25%	15%	29%	32%	41	13	61%	38	23
FLEXI_SIGMOIDOSCOPY	42%	46%	43%	22%	34%	42%	33%	22%	19%	14%	16%	7%	0%	0%	0%	1%	184	1	6%	211	12
GASTROSCOPY	46%	44%	39%	25%	23%	26%	25%	25%	18%	18%	12%	6%	1%	0%	0%	1%	637	5	2%	645	10
MRI	6%	5%	3%	2%	2%	1%	1%	1%	3%	2%	3%	2%	1%	1%	2%	3%	1,868	65	7%	2,716	189
NON_OBSTETRIC_ULTRASOUND	2%	1%	1%	1%	2%	1%	0%	1%	1%	3%	2%	5%	5%	4%	8%	13%	4,997	644	17%	5,120	881
PERIPHERAL_NEUROPHYS	90%	89%	92%	96%	84%	84%	73%	69%	62%	30%	6%	5%	0%	0%	0%	0%	712	0	21%	288	60
SLEEP_STUDIES	2%	1%	1%	1%	2%	3%	3%	9%	15%	15%	9%	6%	4%	6%	0%	3%	166	5	28%	224	63
URODYNAMICS	56%	59%	49%	59%	66%	67%	50%	63%	52%	54%	34%	11%	27%	3%	7%	5%	55	3	25%	28	7
NWL	36%	37%	37%	33%	30%	27%	23%	21%	22%	19%	12%	13%	11%	10%	13%	9%	11,619	1,044	14%	13,152	1,817

RAG Rating
<5%
5-10%
>10%

Please note we are clarifying with NHSE the change from 1% to 5% of the national target for Diagnostic Waiting Times within 6 weeks, specified in: [Delivery Plan for Tackling the COV-19 Backlog of Elective Care](#)

Percentage of Patients Waiting over 6weeks (by modality)

Diagnostic Waiting Times and Activity (DM01) - LNWH

	2021/22 (Validated)												2022/23								
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22		Latest week (28-08-2022)			
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	Waiting List Size	>6wks	>6wks %	Waiting List Size	>6wks
AUDIOLOGY_ASSESSMENTS	2%	4%	0%	0%	0%	1%	1%	15%	9%	55%	42%	0%	1%	0%	1%	0%	73	0	67%	9	6
BARIUM_ENEMA																	0	0			
COLONOSCOPY	15%	5%	9%	12%	8%	6%	6%	3%	7%	4%	3%	5%	9%	7%	9%	6%	427	26	8%	407	31
CT	0%	0%	0%	1%	0%	3%	4%	5%	9%	10%	9%	7%	10%	9%	9%	9%	1,394	123	8%	1,486	123
CYSTOSCOPY	5%	7%	10%	13%	13%	11%	12%	20%	23%	21%	5%	23%	19%	26%	19%	31%	132	41	39%	160	63
DEXA_SCAN	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	265	0	0%	273	0
ECHOCARDIOGRAPHY	0%	0%	0%	0%	1%	0%	0%	1%	0%	2%	0%	10%	9%	3%	8%	1%	740	6	3%	597	17
ELECTROPHYSIOLOGY																	0	0		0	0
FLEXI_SIGMOIDOSCOPY	10%	9%	6%	17%	16%	5%	6%	3%	8%	6%	3%	7%	8%	7%	9%	7%	117	8	10%	94	9
GASTROSCOPY	19%	10%	11%	18%	12%	6%	7%	7%	9%	11%	6%	6%	10%	7%	5%	8%	438	33	11%	376	40
MRI	0%	0%	0%	1%	1%	0%	0%	2%	5%	7%	2%	3%	2%	2%	1%	1%	1,978	14	1%	2,049	25
NON_OBSTETRIC_ULTRASOUND	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	2%	0%	0%	0%	2,546	2	0%	2,722	5
PERIPHERAL_NEUROPHYS	0%	0%	0%	9%	2%	3%	5%	6%	12%	1%	0%	1%	1%	2%	0%	0%	149	0	4%	187	7
SLEEP_STUDIES	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	54	0	6%	33	2
URODYNAMICS	0%	30%	50%	42%	74%	36%	46%	43%	77%	27%	12%	20%	27%	15%	0%	11%	35	4	57%	21	12
NWL	3%	1%	2%	3%	2%	2%	2%	3%	5%	6%	3%	4%	5%	4%	4%	3%	8,348	257	4%	8,414	340

RAG Rating
<5%
5-10%
>10%

Please note we are clarifying with NHSE the change from 1% to 5% of the national target for Diagnostic Waiting Times within 6 weeks, specified in: [Delivery Plan for Tackling the COV-19 Backlog of Elective Care](#)

Percentage of Patients Waiting over 6weeks (by modality)

Diagnostic Waiting Times and Activity (DM01) - THH

	2021/22 (Validated)												2022/23								
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22		Latest week (28-08-2022)			
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	>6wks %	Waiting List Size	>6wks	>6wks %	Waiting List Size	>6wks
AUDIOLOGY_ASSESSMENTS	0%	0%	1%	2%	3%	3%	2%	3%	13%	23%	15%	23%	34%	27%	22%	24%	523	127	35%	608	214
BARIUM_ENEMA	73%	69%	63%	76%	81%	72%	71%	66%	60%	49%	44%	23%	27%	14%	10%	8%	40	3	13%	32	4
COLONOSCOPY	47%	33%	27%	28%	30%	24%	22%	29%	34%	38%	27%	29%	35%	27%	31%	32%	521	168	31%	520	160
CT	10%	5%	1%	1%	4%	0%	5%	17%	37%	37%	18%	5%	5%	1%	0%	1%	426	3	1%	368	5
CYSTOSCOPY	49%	53%	63%	56%	60%	62%	65%	73%	54%	71%	65%	62%	67%	58%	35%	16%	64	10	18%	51	9
DEXA_SCAN																	0	0		0	0
ECHOCARDIOGRAPHY	9%	25%	29%	26%	30%	39%	27%	32%	48%	55%	51%	57%	65%	51%	55%	68%	1,250	848	69%	1,207	833
ELECTROPHYSIOLOGY																	0	0		0	0
FLEXI_SIGMOIDOSCOPY	51%	40%	32%	43%	33%	42%	28%	24%	44%	63%	43%	45%	47%	54%	44%	40%	93	37	42%	92	39
GASTROSCOPY	61%	52%	43%	36%	42%	47%	31%	33%	41%	51%	40%	43%	44%	38%	42%	42%	425	177	42%	462	193
MRI	13%	30%	41%	51%	56%	53%	61%	32%	21%	11%	9%	3%	2%	4%	15%	24%	1,163	275	35%	1,354	469
NON_OBSTETRIC_ULTRASOUND	14%	24%	21%	22%	18%	10%	8%	13%	14%	16%	9%	12%	26%	18%	29%	29%	4,260	1246	31%	3,869	1,214
PERIPHERAL_NEUROPHYS																	0	0			
SLEEP_STUDIES																	0	0			
URODYNAMICS	67%	62%	29%	36%	45%	58%	37%	51%	53%	56%	47%	64%	8%	24%	38%	15%	48	7	47%	49	23
NWL	21%	27%	27%	30%	32%	30%	26%	23%	29%	33%	25%	26%	33%	27%	31%	33%	8,813	2,901	37%	8,612	3,163

RAG Rating
<5%
5-10%
>10%

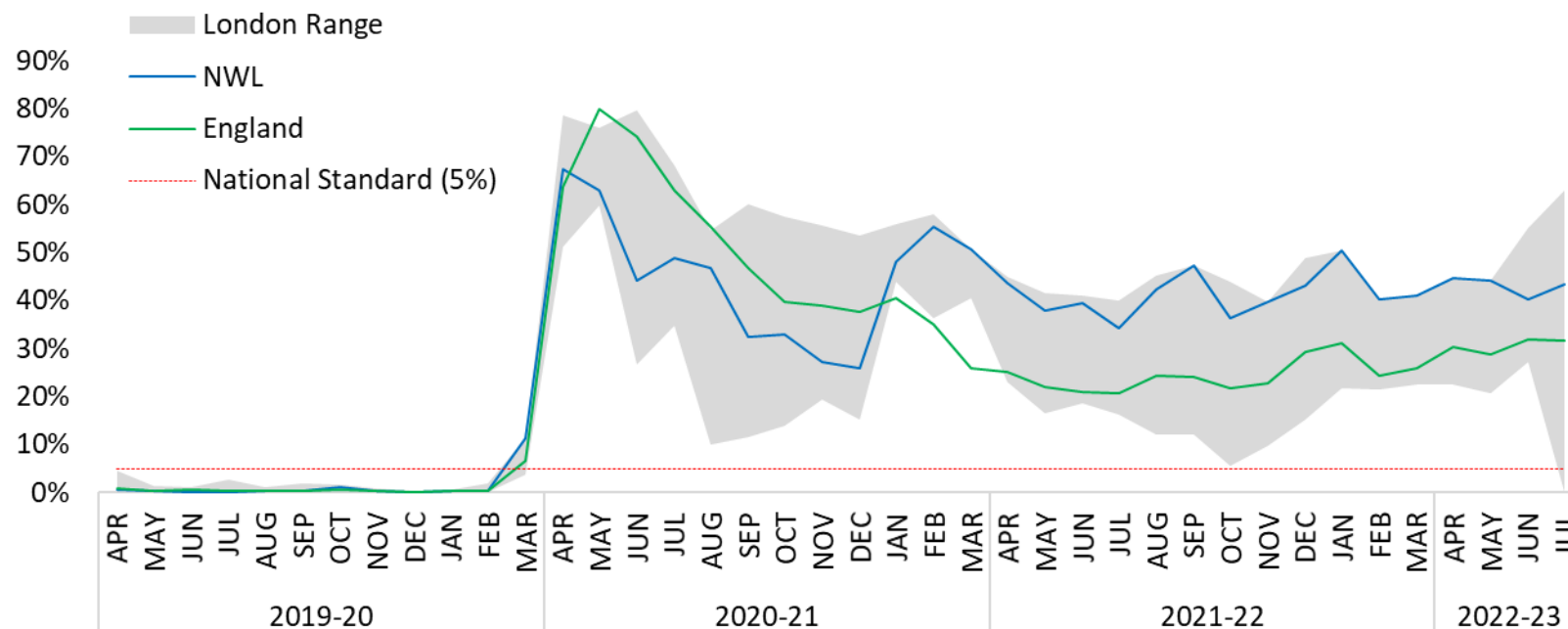
Please note we are clarifying with NHSE the change from 1% to 5% of the national target for Diagnostic Waiting Times within 6 weeks, specified in: [Delivery Plan for Tackling the COV-19 Backlog of Elective Care](#)

Audiology

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Audiology_Assessments



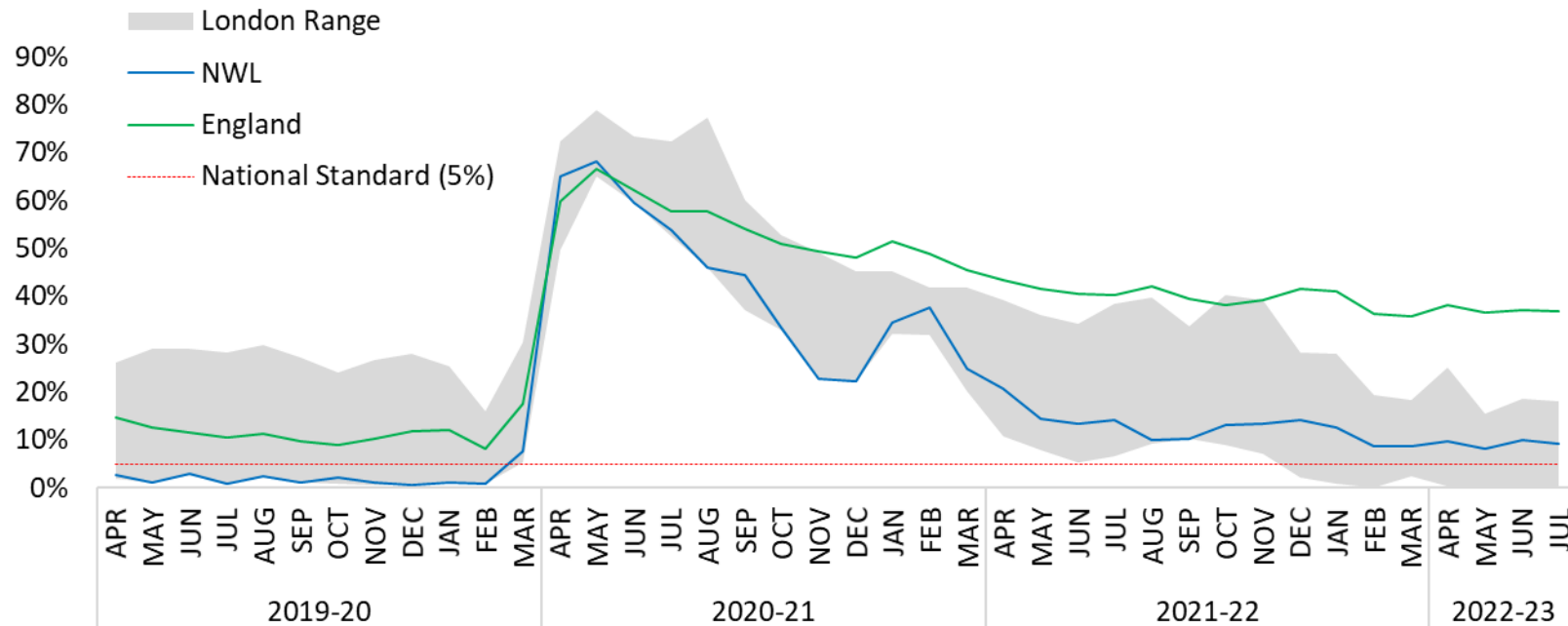
Trust	# Breaches	% Breaches
CW	2	1%
ICTH	839	56%
LNW	0	0%
THH	127	24%

Colonoscopy

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Colonoscopy



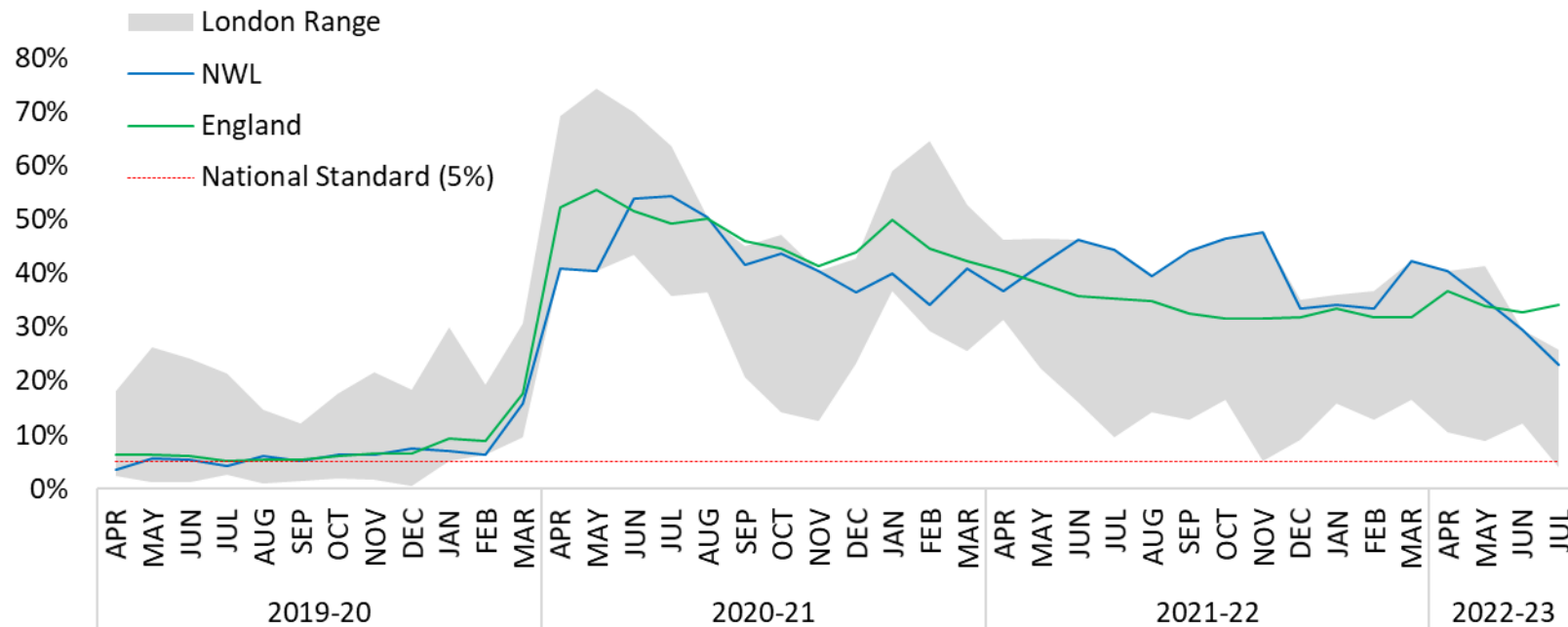
Trust	# Breaches	% Breaches
CW	4	1%
ICTH	0	0%
LNW	26	6%
THH	168	32%

Cystoscopy

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Cystoscopy



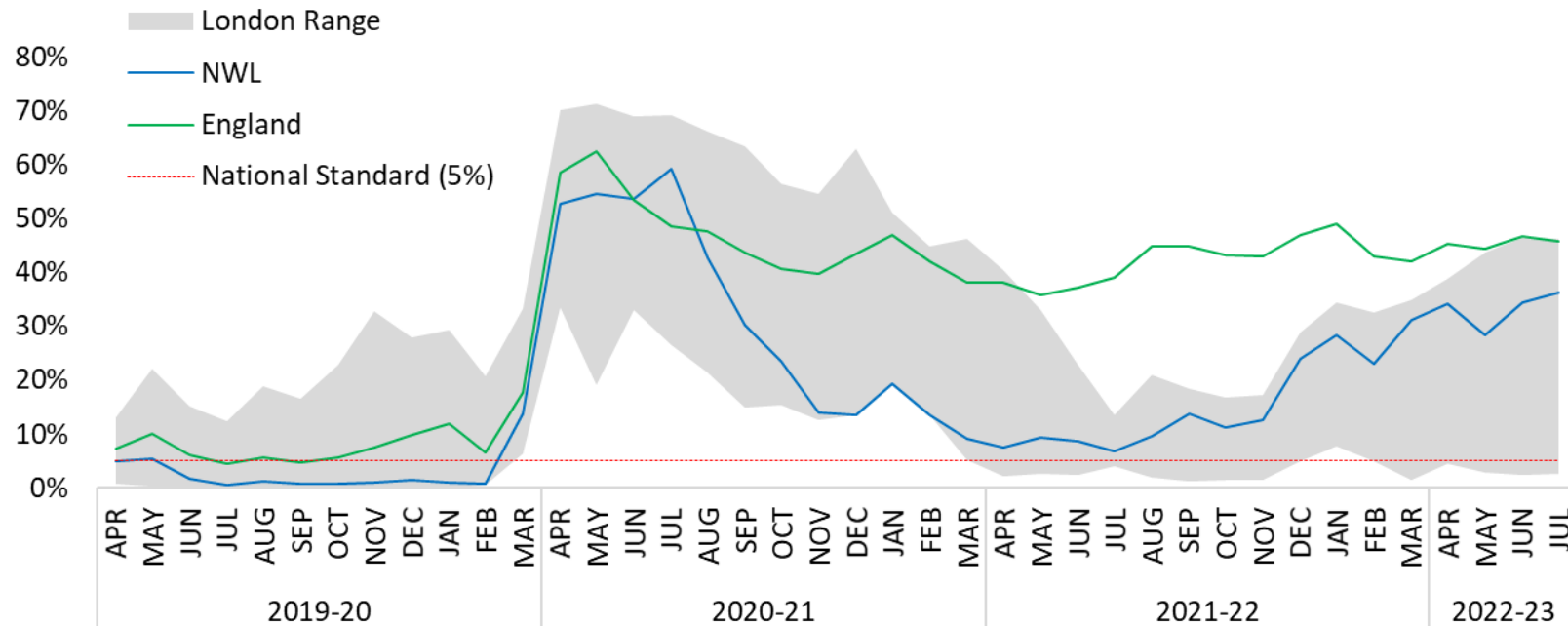
Trust	# Breaches	% Breaches
CW	44	14%
ICHT	51	40%
LNW	41	31%
THH	10	16%

Echocardiography

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Echocardiography



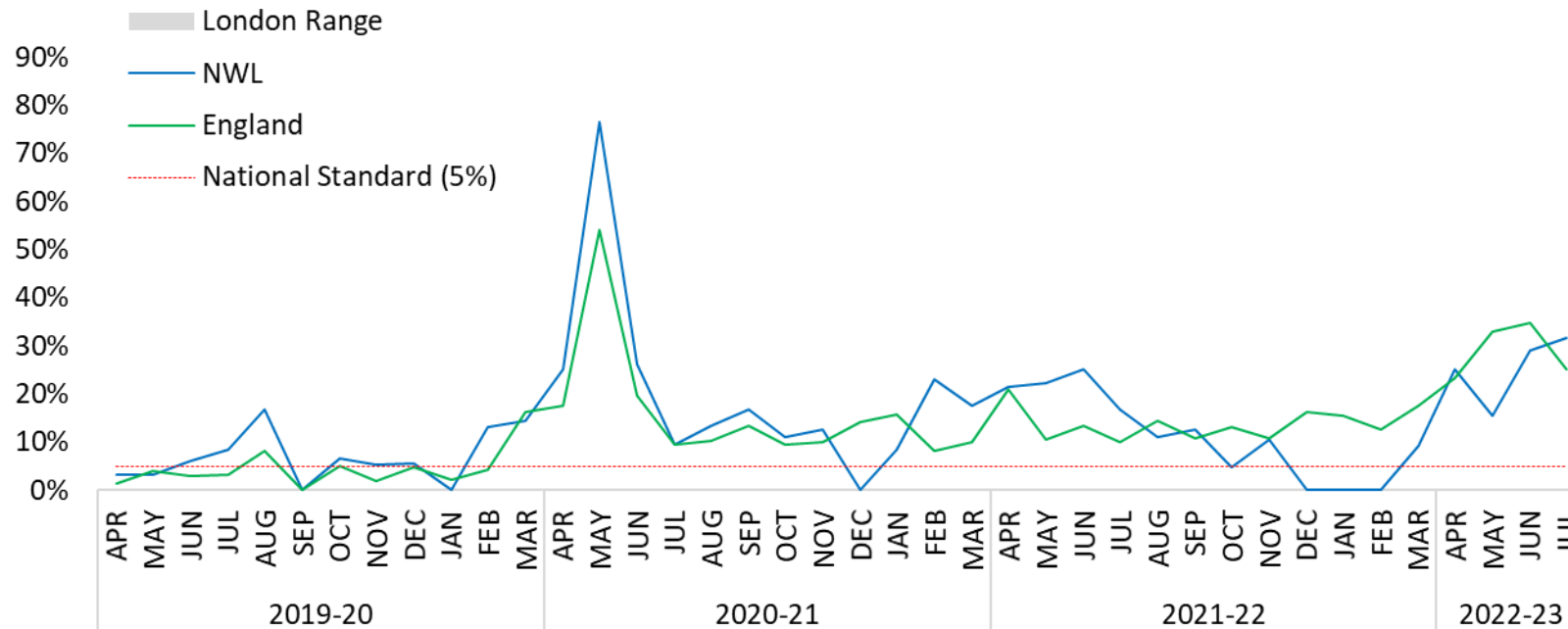
Trust	# Breaches	% Breaches
CW	1	0%
ICHT	190	46%
LNW	6	1%
THH	848	68%

Electrophysiology

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Electrophysiology



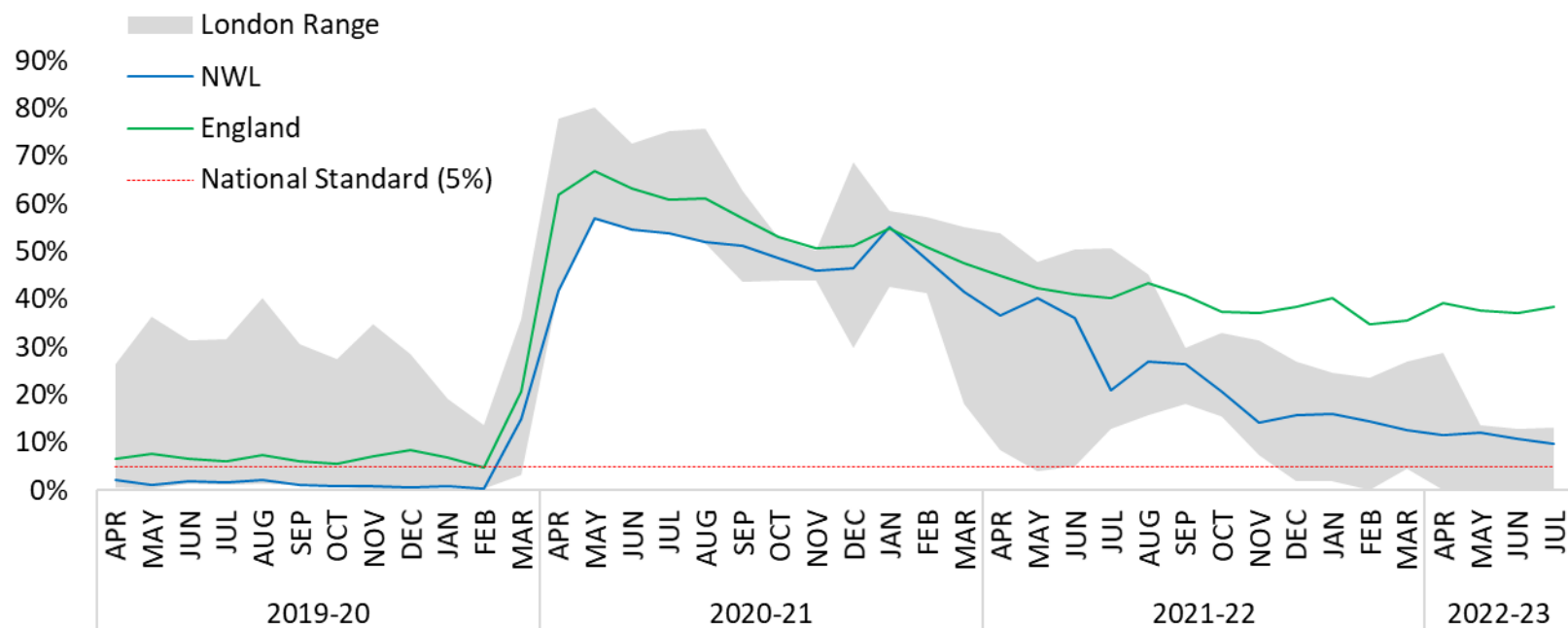
Trust	# Breaches	% Breaches
CW		
ICHT	13	32%
LNW		
THH		

Flexi-sigmoidoscopy

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Flexi-sigmoidoscopy



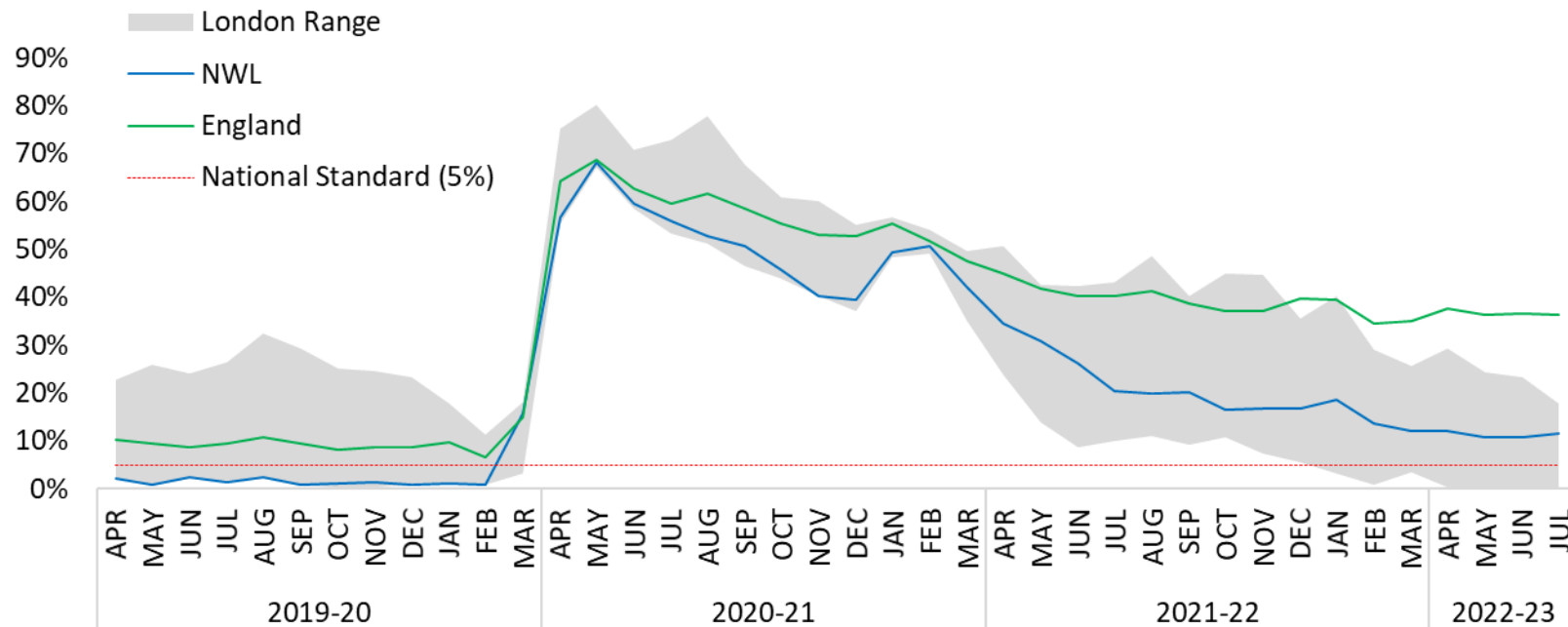
Trust	# Breaches	% Breaches
CW	6	4%
ICHT	1	1%
LNW	8	7%
THH	37	40%

Gastroscopy

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

Modality: Gastroscopy

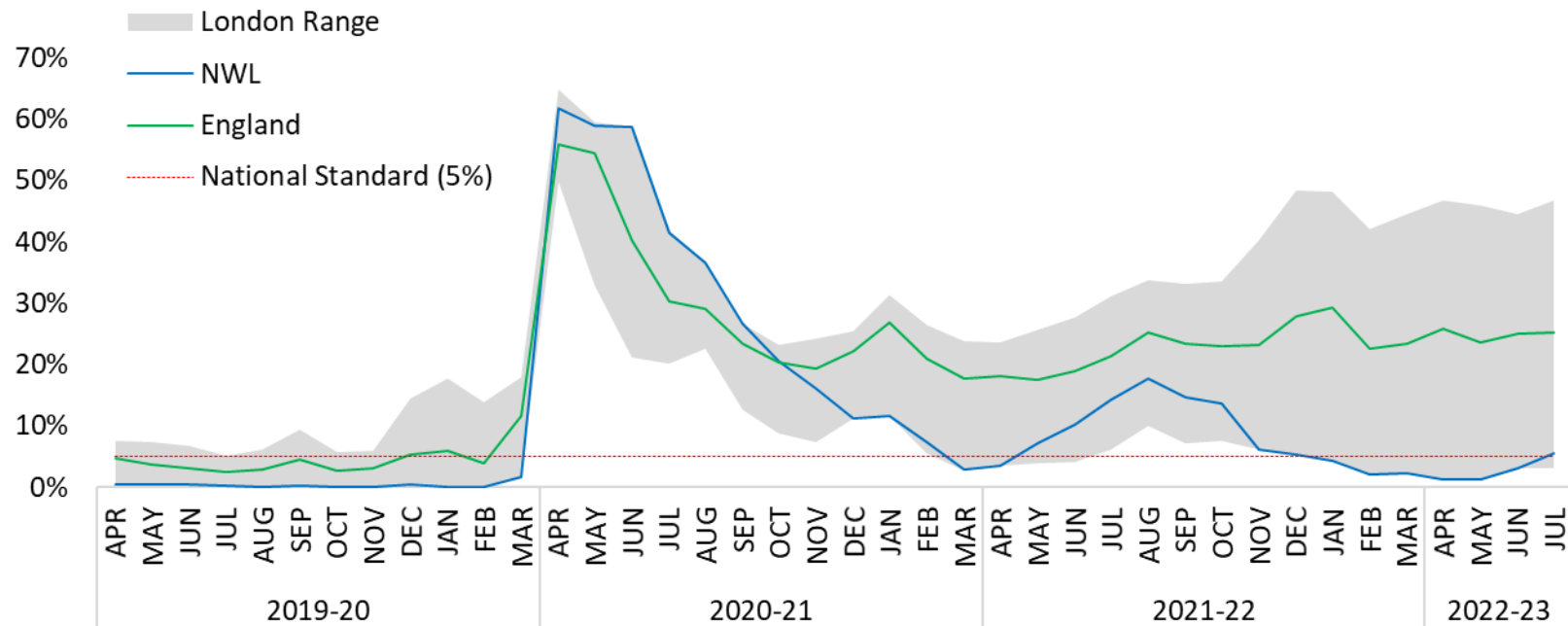


Trust	# Breaches	% Breaches
CW	5	1%
ICHT	5	1%
LNW	33	8%
THH	177	42%

% Waiting over 6 weeks for Diagnostic Tests

Provider: NWL

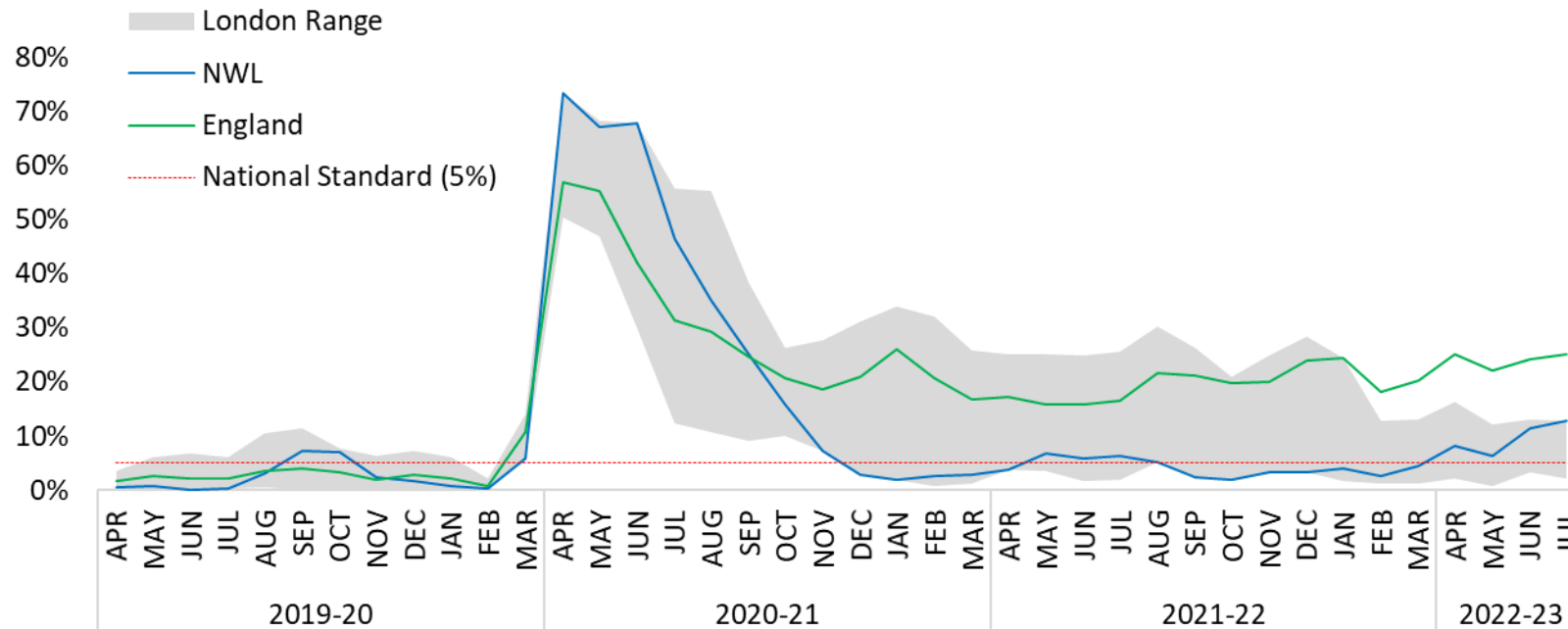
Modality: MRI



Trust	# Breaches	% Breaches
CW	2	0%
ICHT	56	3%
LNW	14	1%
THH	275	24%

Non-obstetric ultrasound

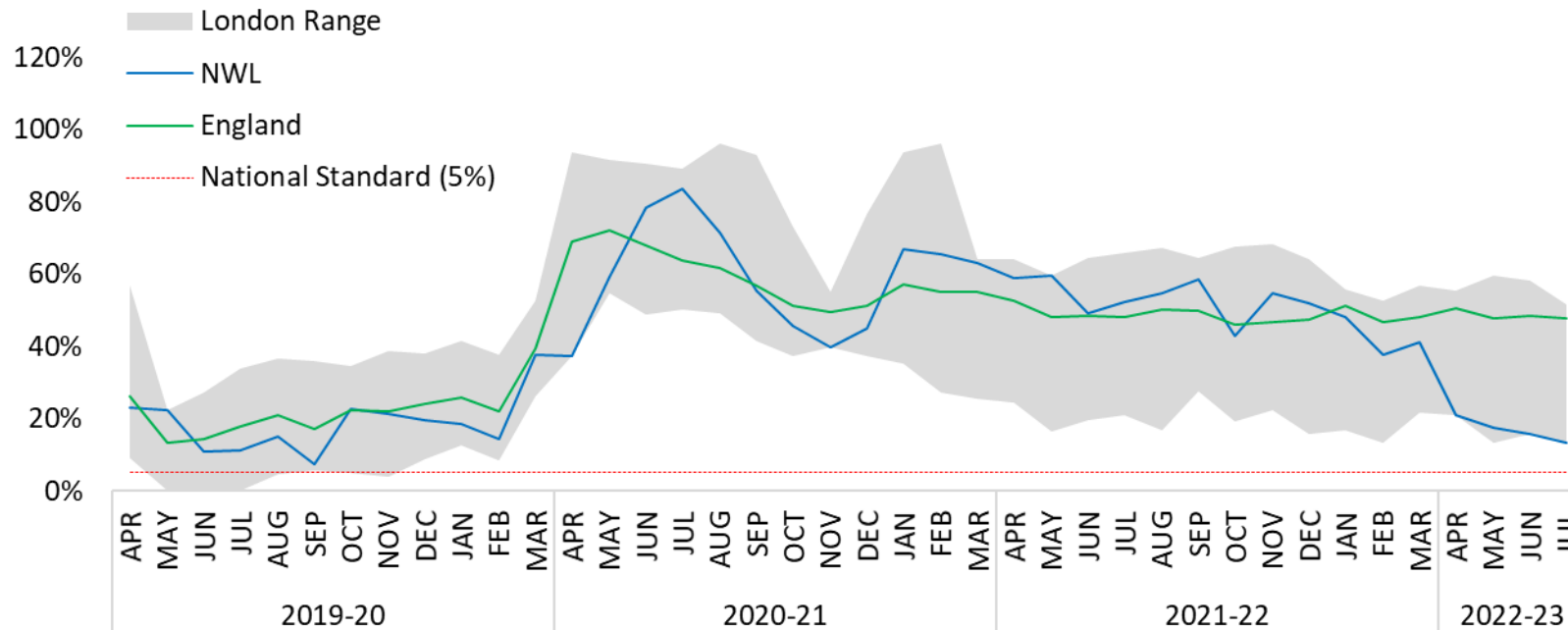
% Waiting over 6 weeks for Diagnostic Tests
 Provider: NWL
 Modality: Non_obstetric_ultrasound



Trust	# Breaches	% Breaches
CW	0	0%
ICHT	644	13%
LNW	2	0%
THH	1246	29%

Urodynamics

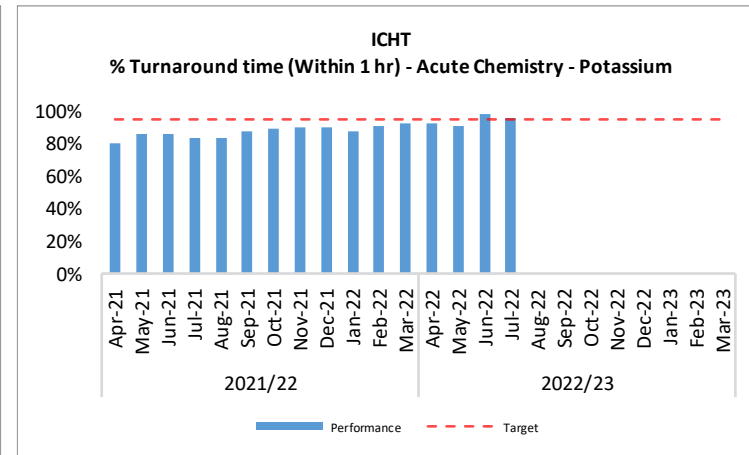
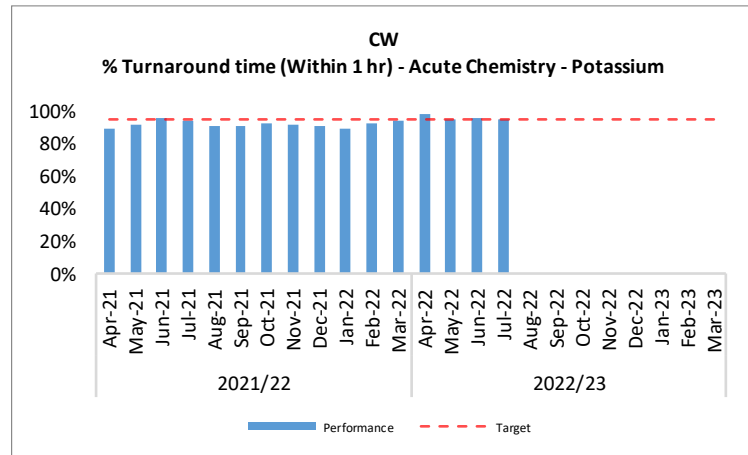
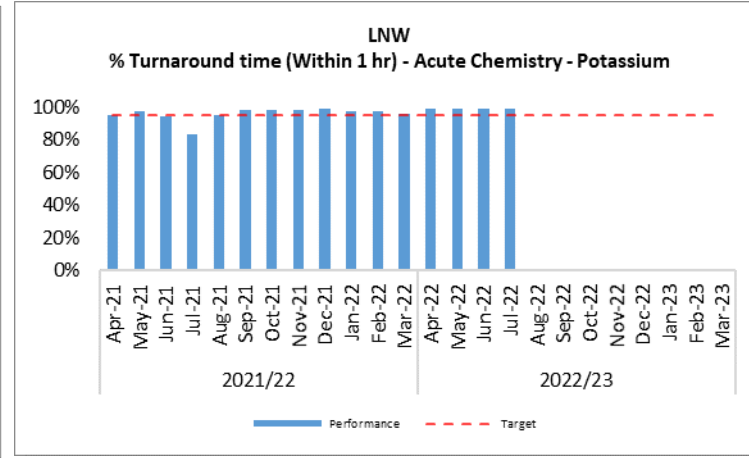
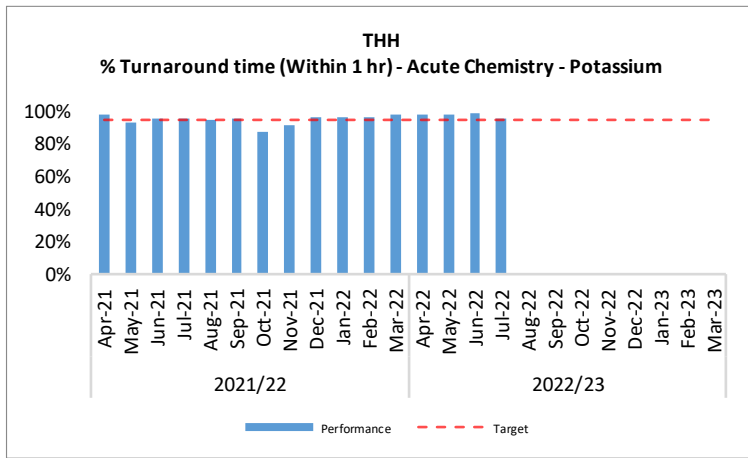
% Waiting over 6 weeks for Diagnostic Tests
 Provider: NWL
 Modality: Urodynamics



Trust	# Breaches	% Breaches
CW	6	50%
ICHT	3	5%
LNW	4	11%
THH	7	15%

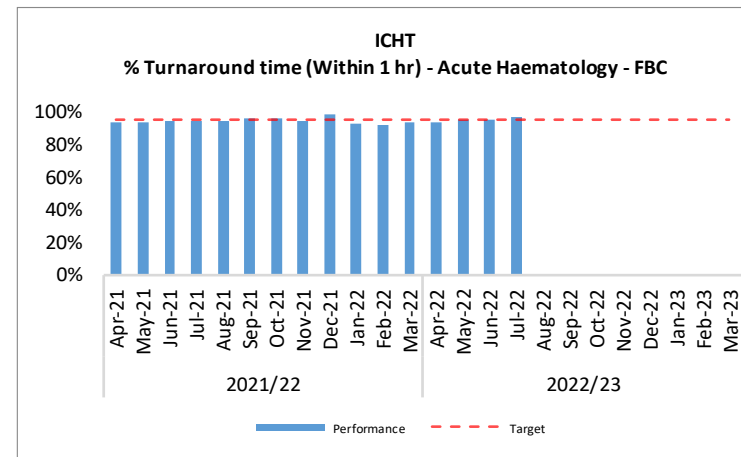
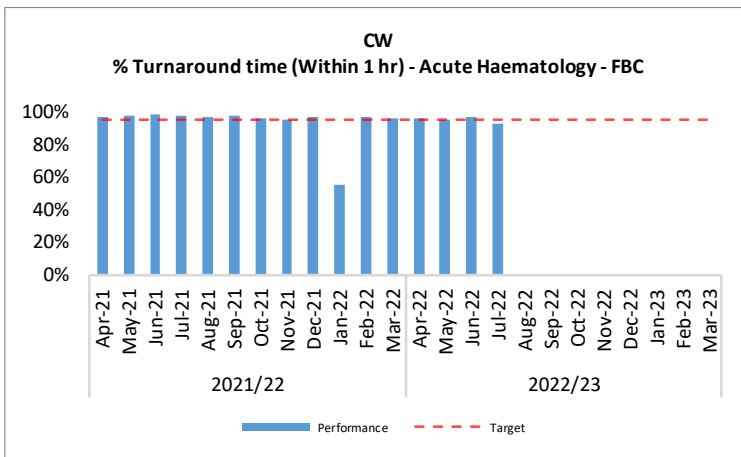
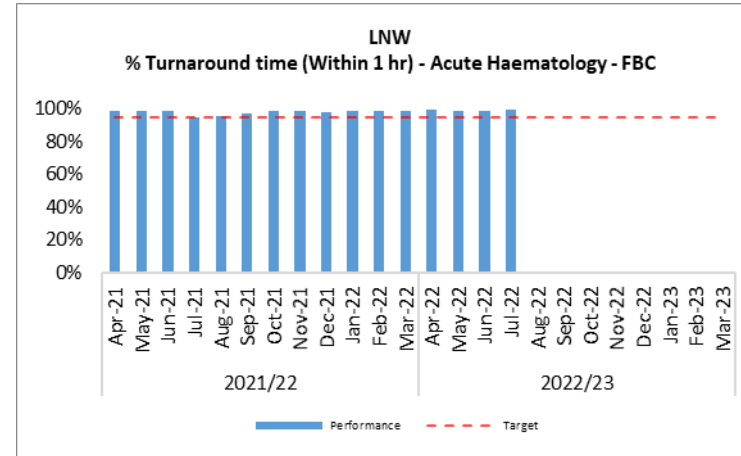
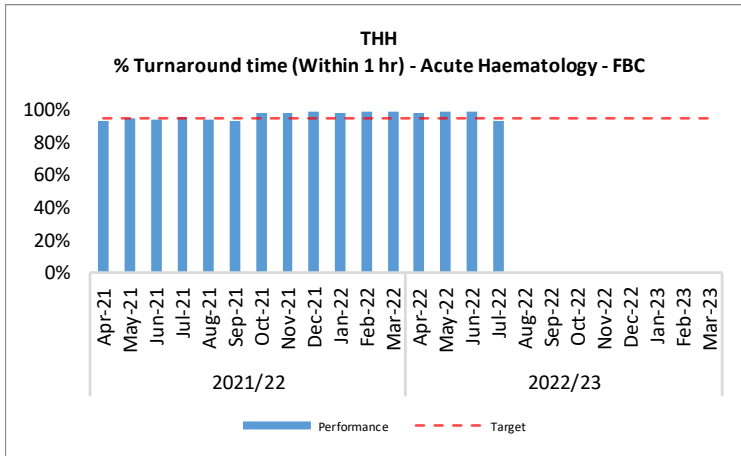
Acute Chemistry - Potassium

% Turnaround time (Within 1 hr)

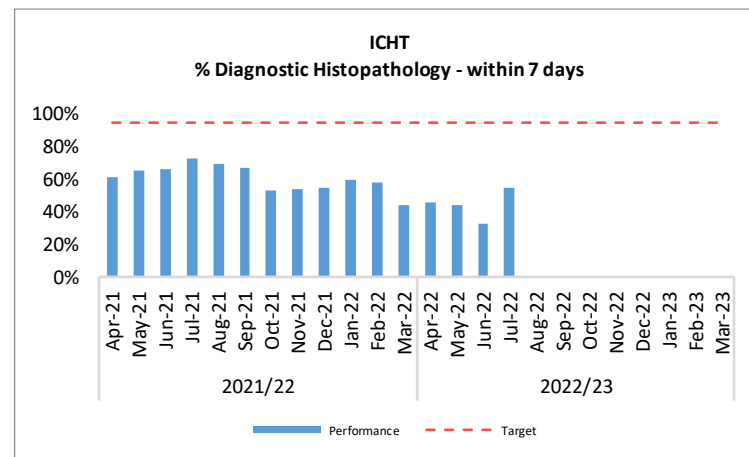
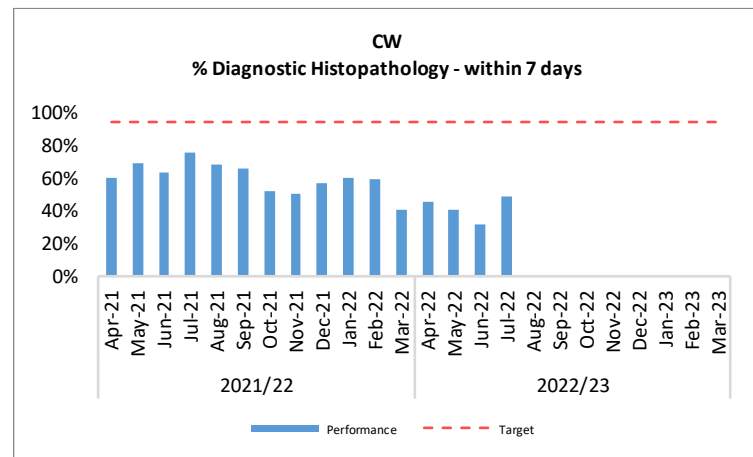
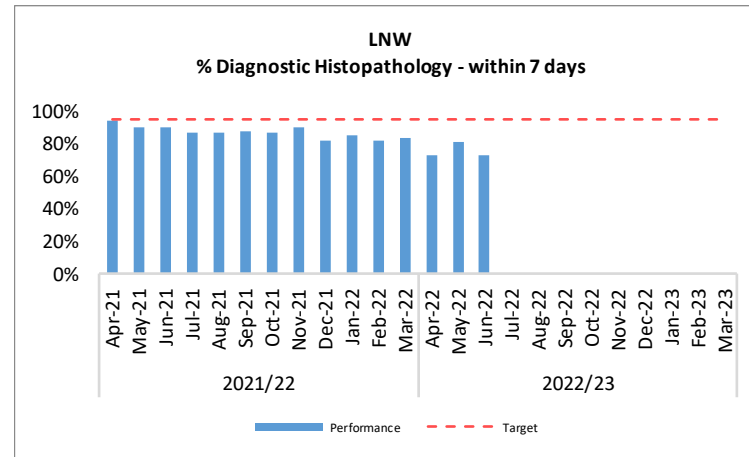
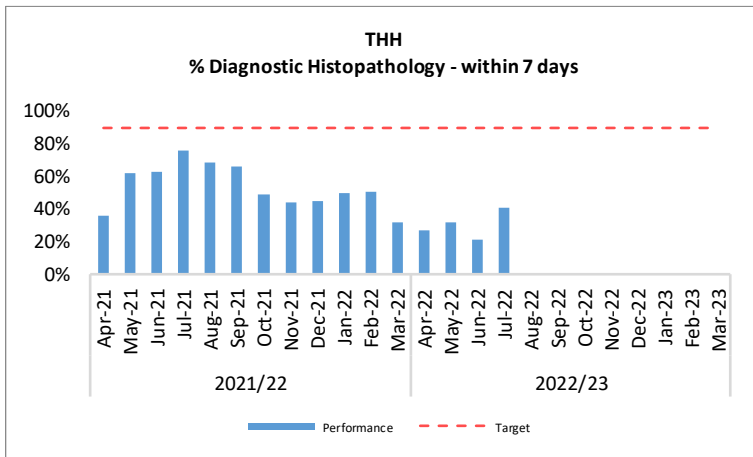


Acute Haematology – FBC

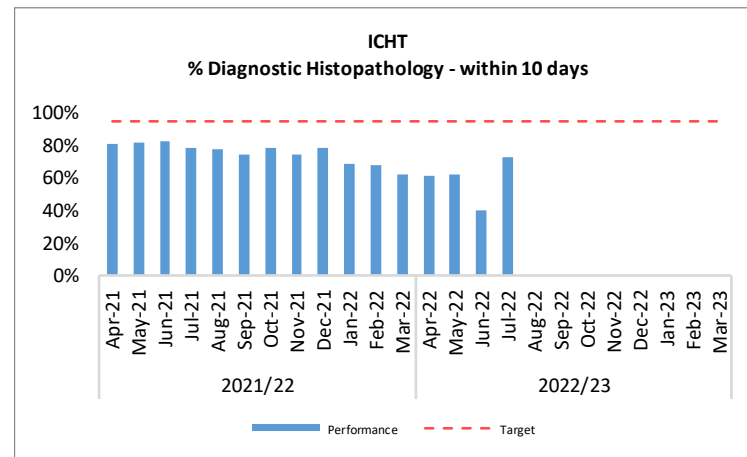
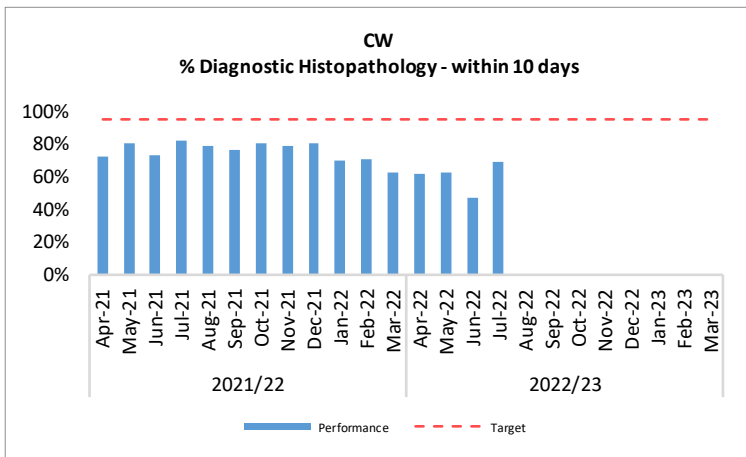
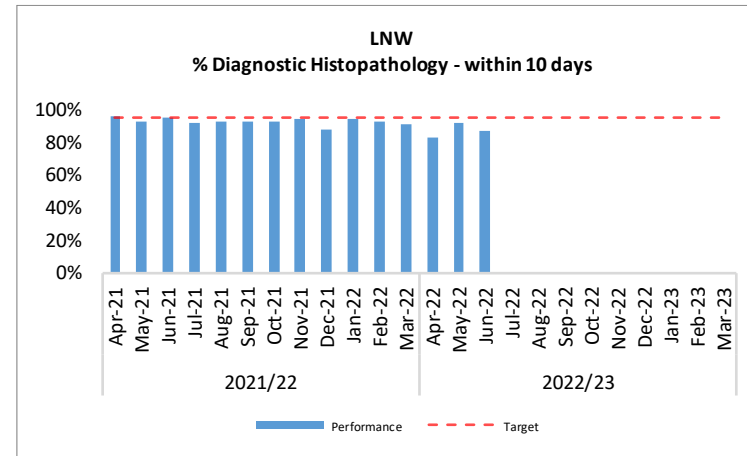
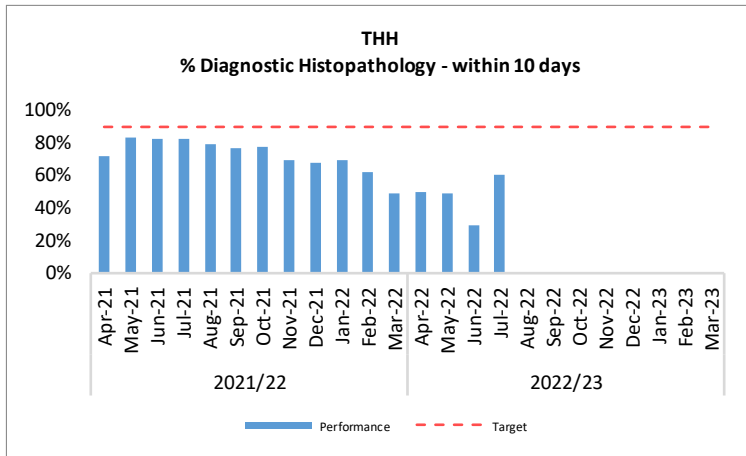
% Turnaround time (Within 1 hr)



% Diagnostic Histopathology - within 7 days



% Diagnostic Histopathology - within 10 days



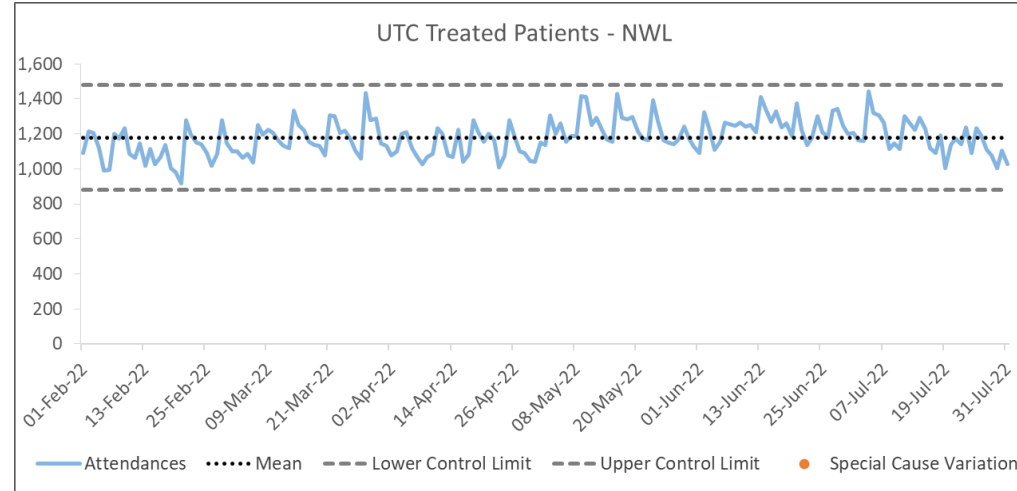
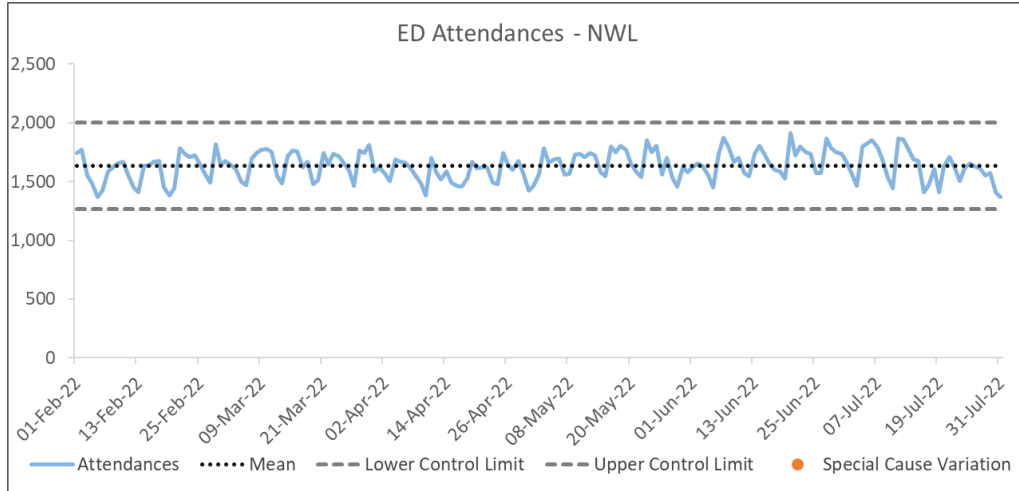
North West London UEC Dashboard

August 2022

Overview: ICS Summary – NWL System

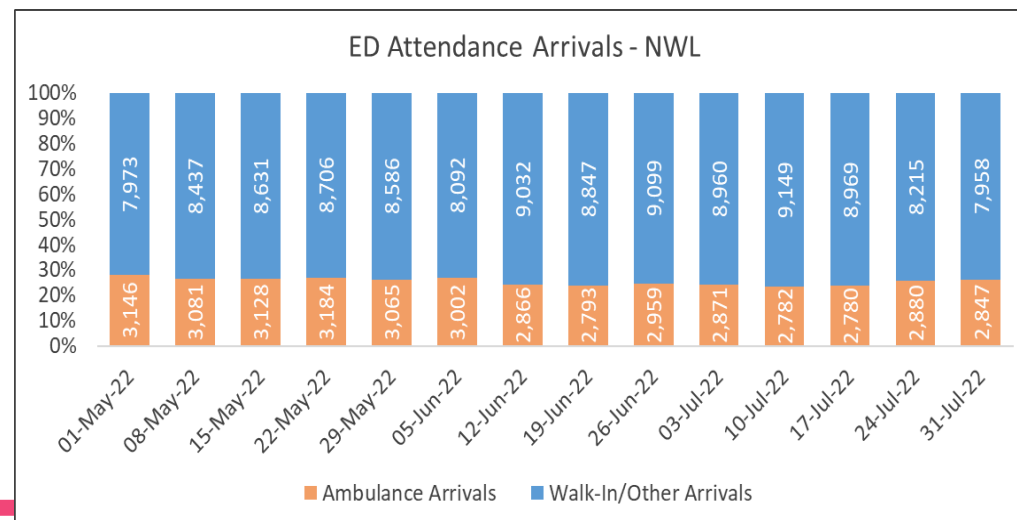
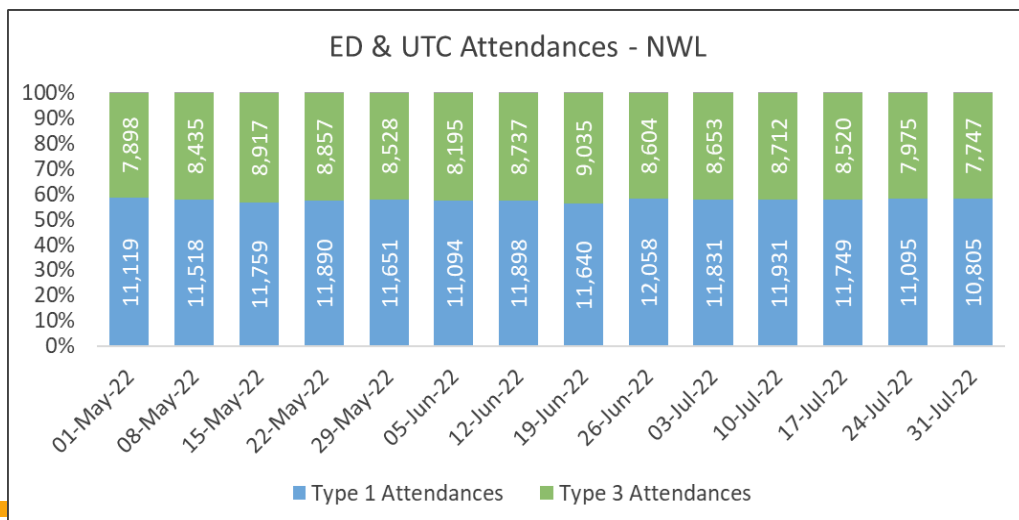
Source: UEC SitRep, Totally SitRep

Latest data up to: 31/07/2022



Highlights

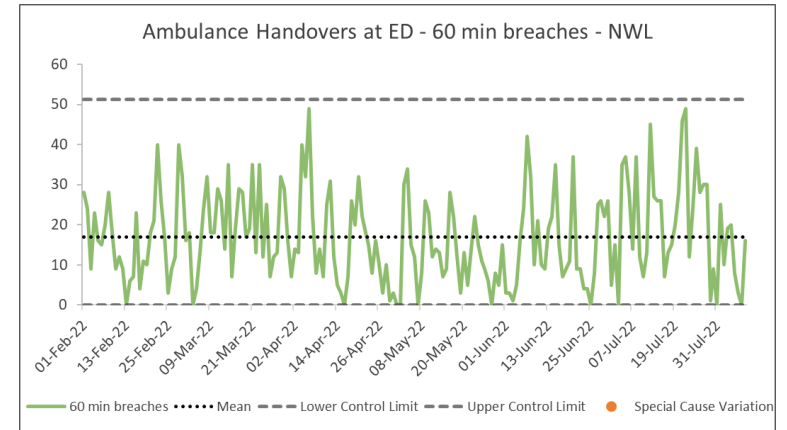
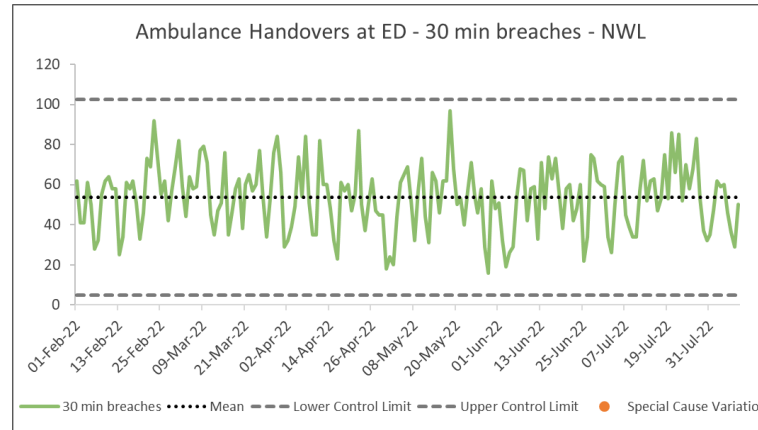
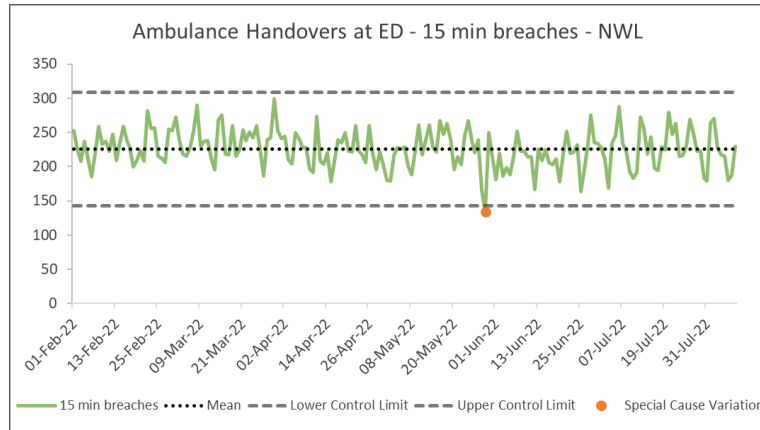
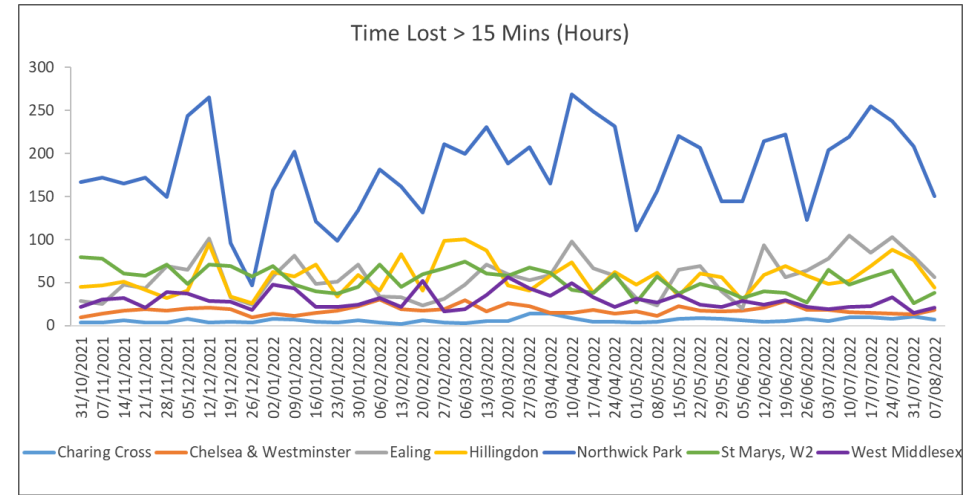
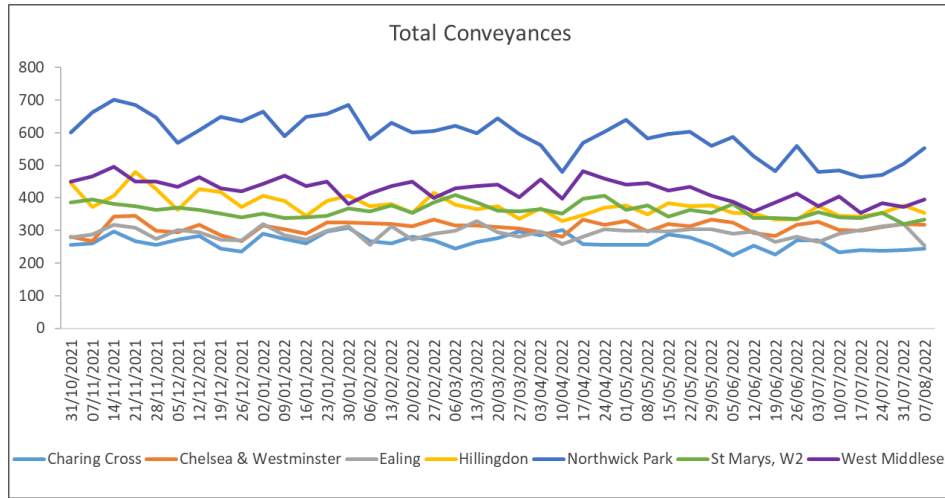
- Demand remains higher than 2019/20 with the consequent pressure on the front door
- UTC demand has grown over the last month, with ED stabilising or reducing



Overview: ICS Summary – LAS conveyances and performance

Source: Ambulance Handover Scorecard, LAS Server

Latest data up to: 07/08/2022

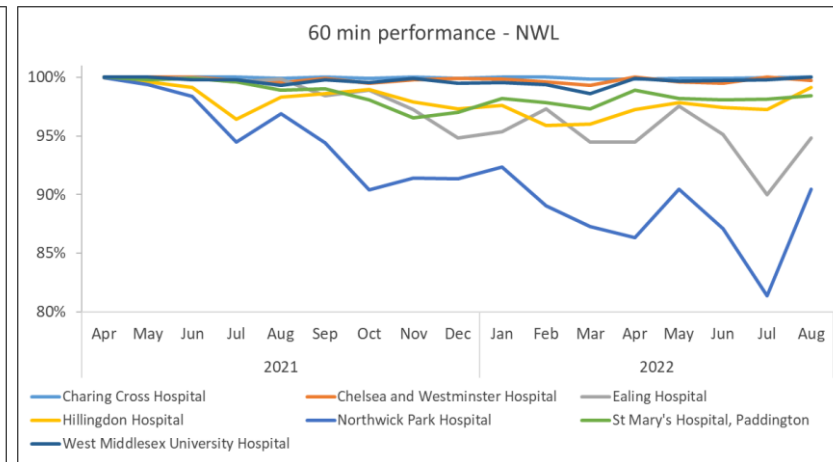
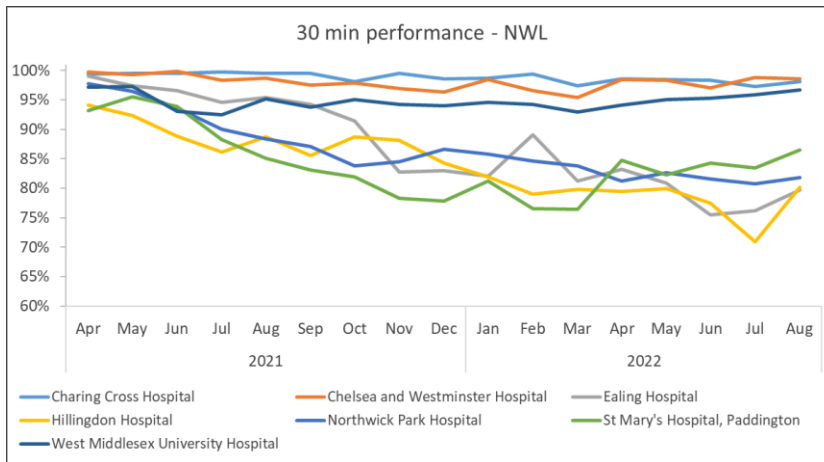
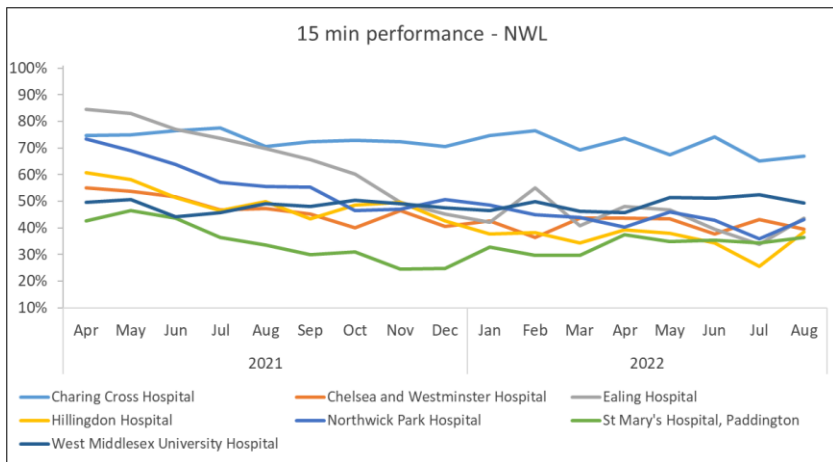
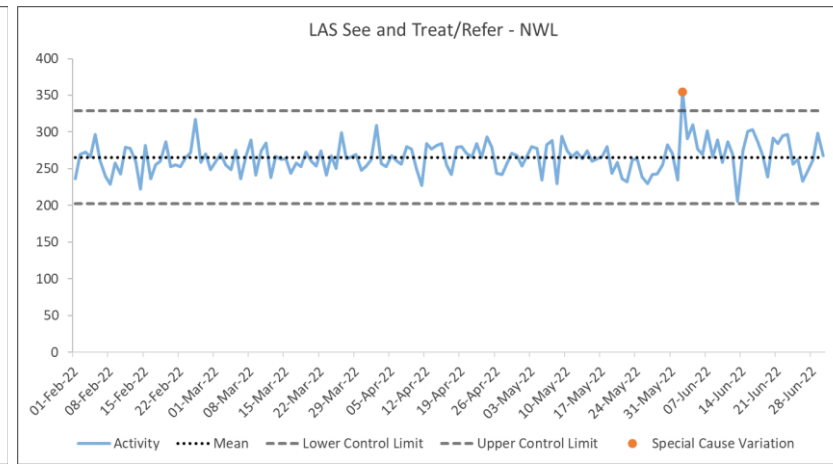
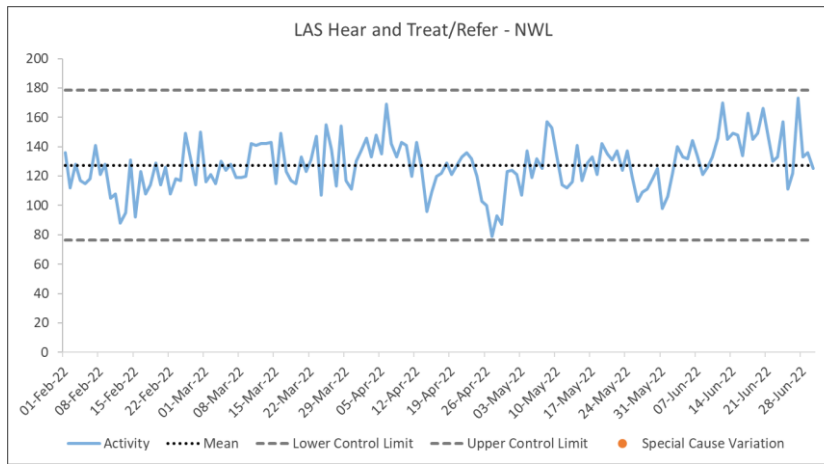
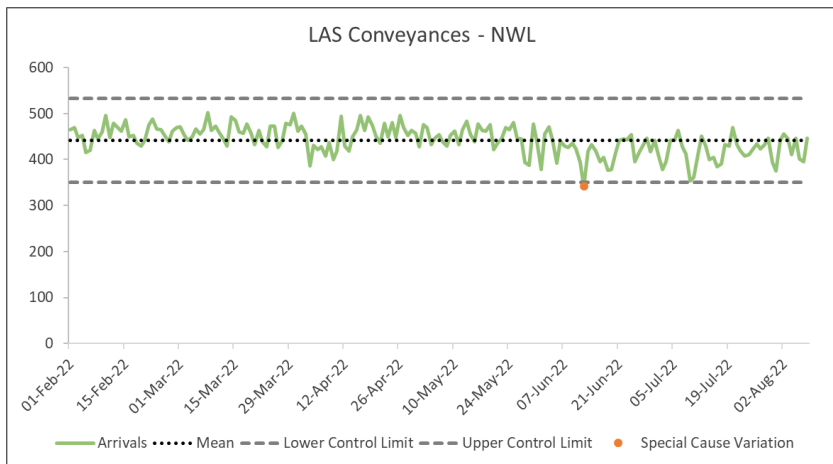


The Step 3 initiative (LAS Escalation ladder) has not had a material impact on the balance of conveyances across the system and handover waits at Northwick Park remain the biggest challenge

Overview: ICS Summary – LAS Conveyances and Hear / See & Treat – NWL view

Source: LAS server (Ambulance Conveyance) – unvalidated, LAS Hear and TreatAS_MDS (Hear / See and Treat) – latest month (Flex)

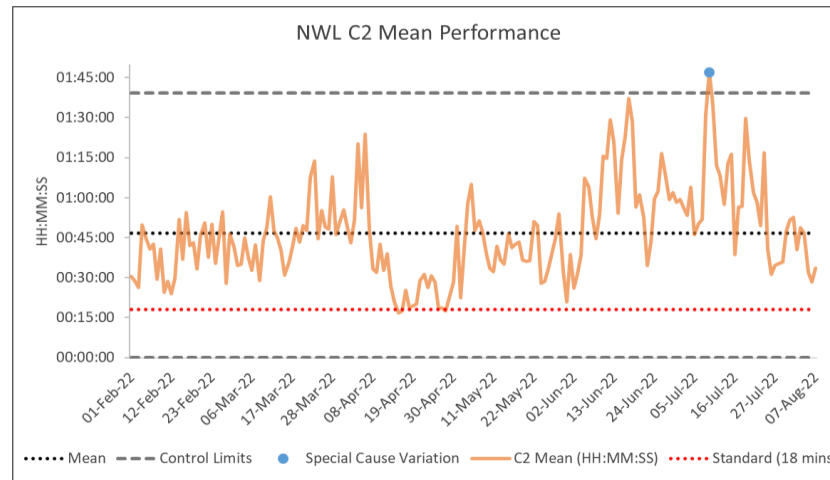
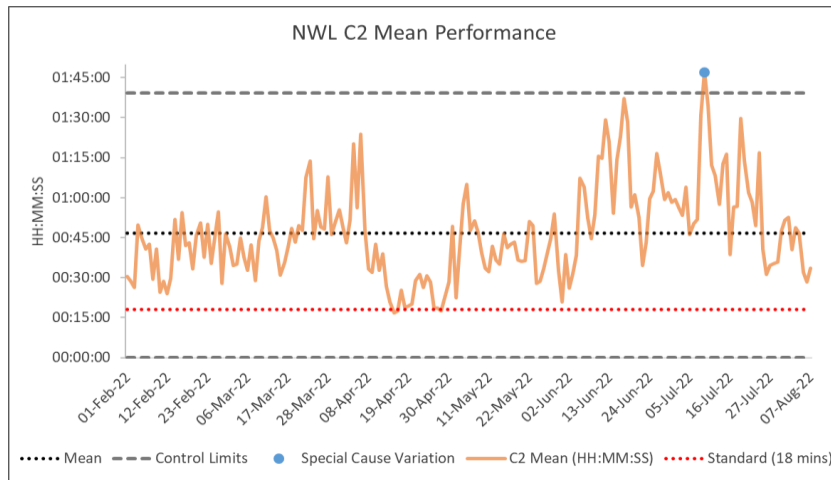
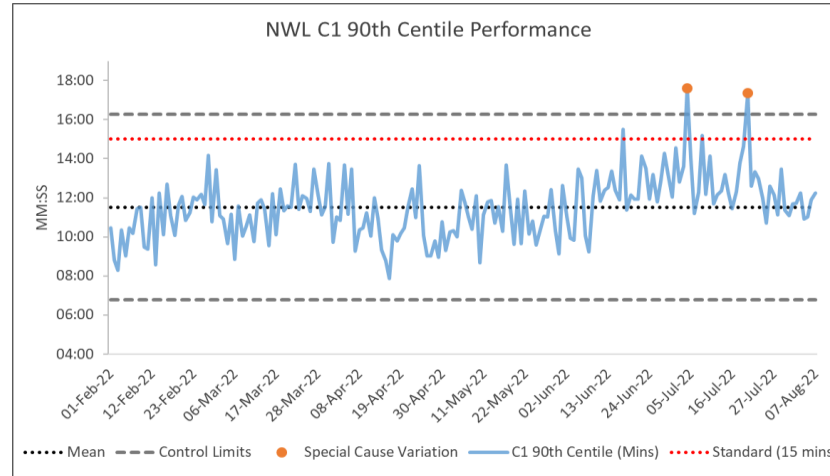
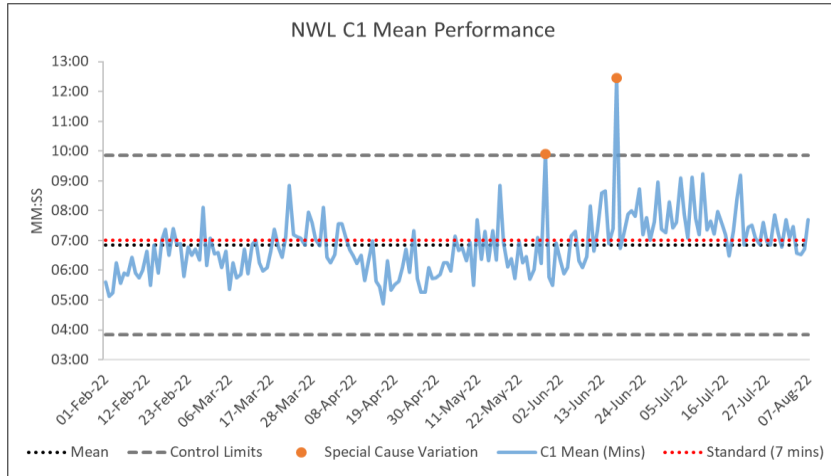
Data up to: 07/08/2022 (conveyances) and M3 22/23



Overview: ICS Summary – LAS C1 C2 Performance

Source: CPM Pack

Latest data up to: 07/08/2022



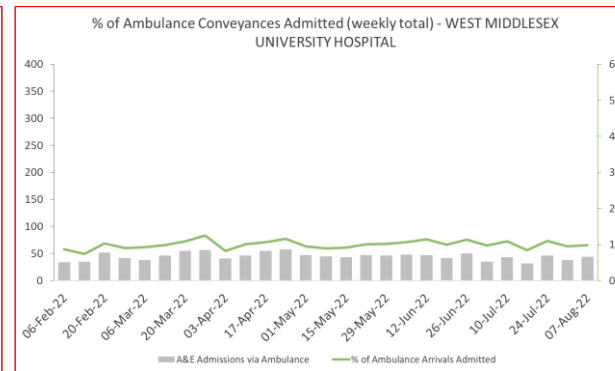
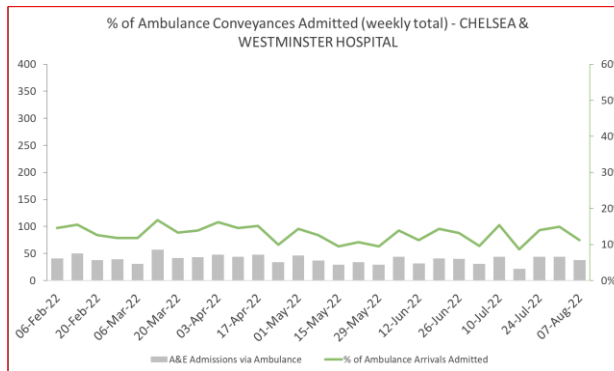
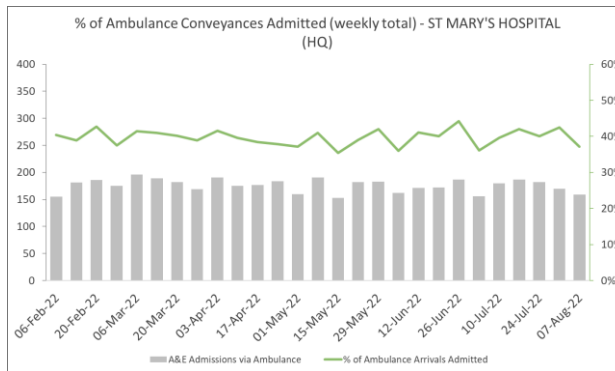
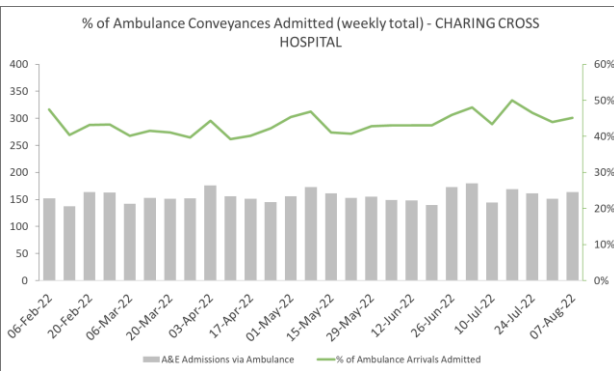
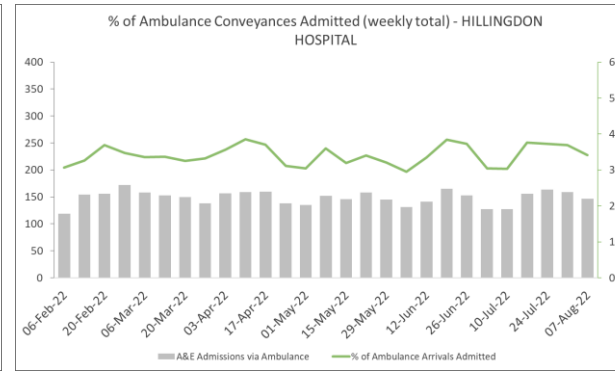
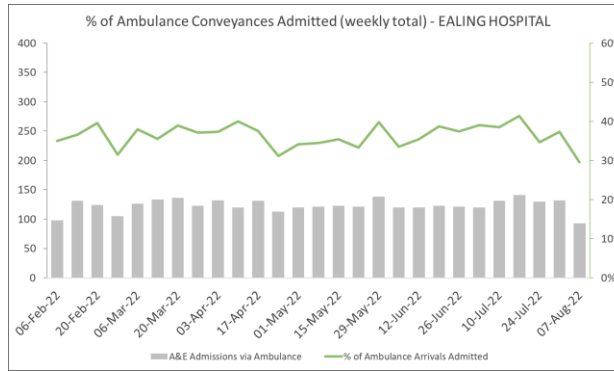
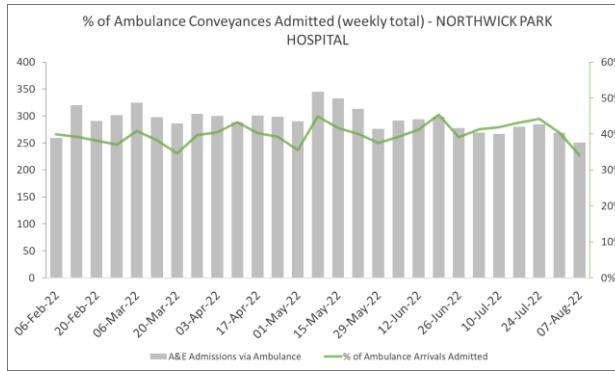
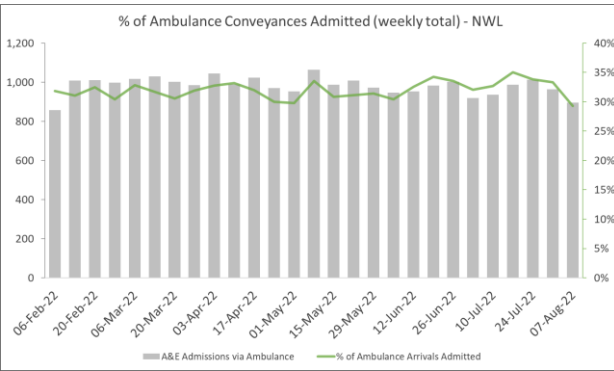
Highlights

- Reported increase in acuity, a factor on the longer waits being recorded with the consequent deterioration in Cat 2 response times
- Cat 1 performance is mostly stable, with some recent exceptions but Cat 2 is challenged again, after a period of good performance over late April/Early June

NWL System: Ambulance Conveyances to Admissions

Source: ECDS

Latest data up to: 07/08/2022

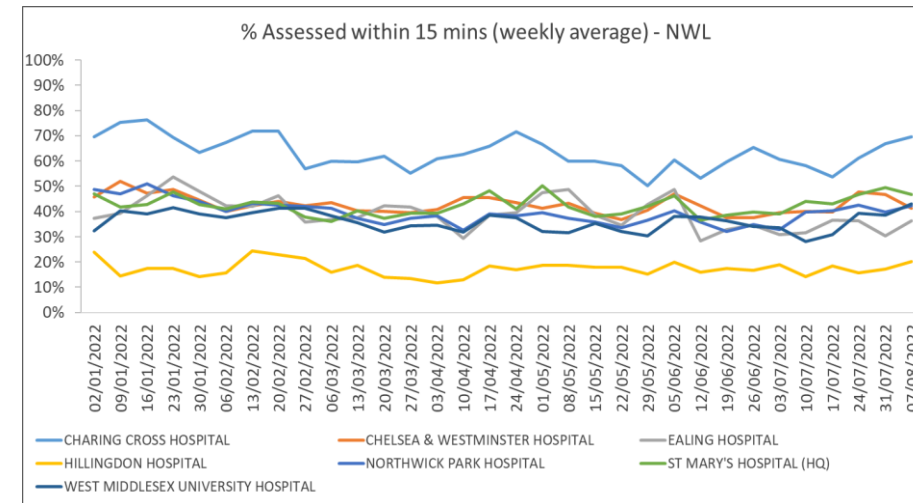
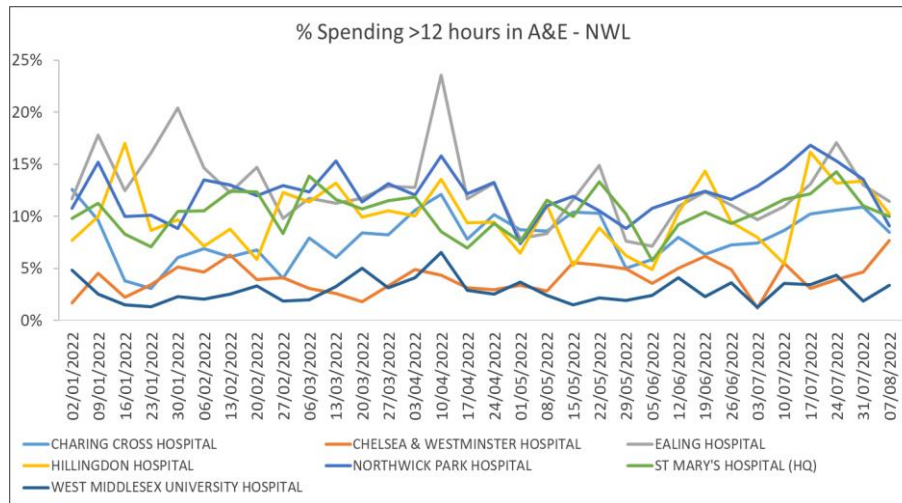
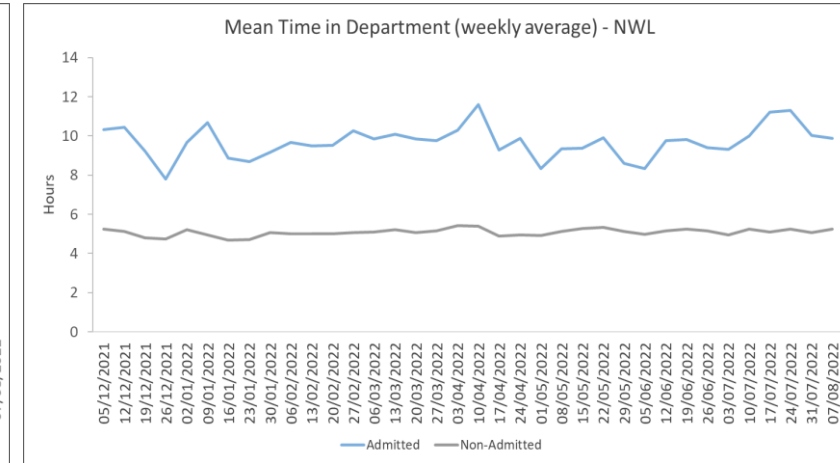
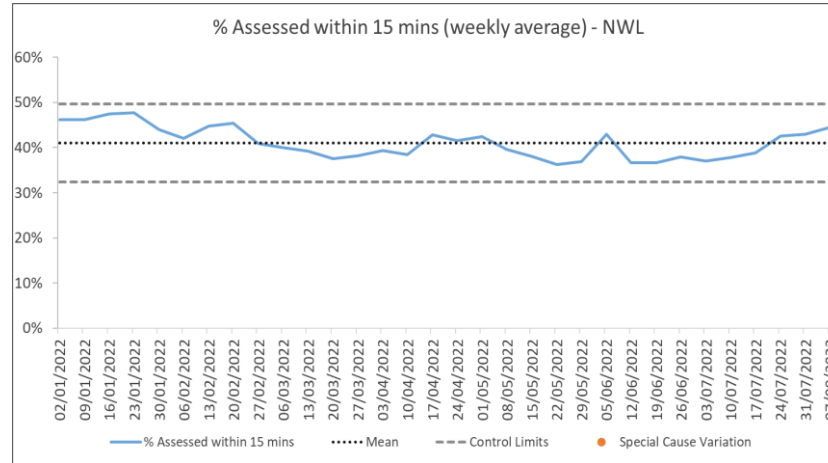
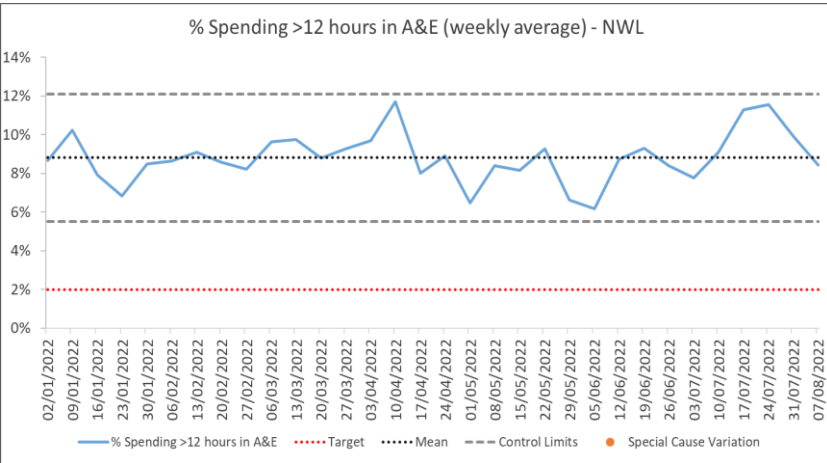


Possible DQ issue for CW and WM sites

Overview: ICS Summary – NWL System

Source: ECDS

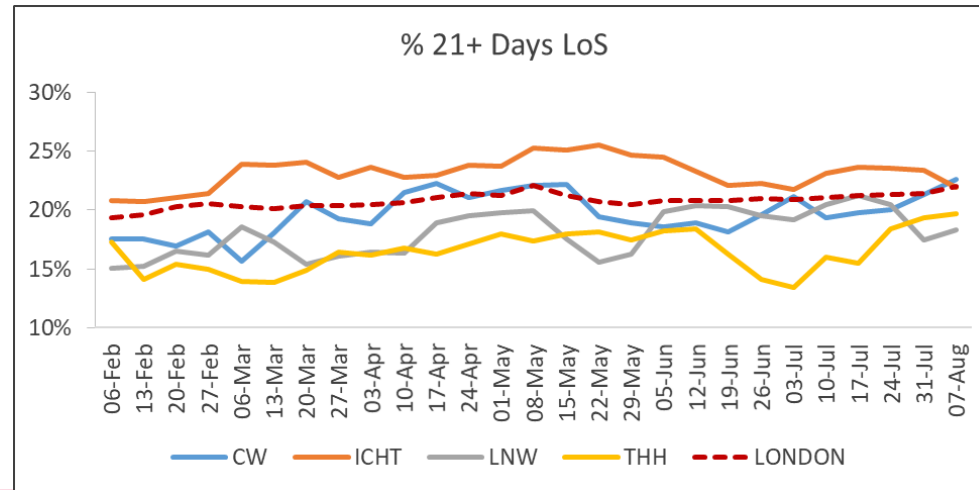
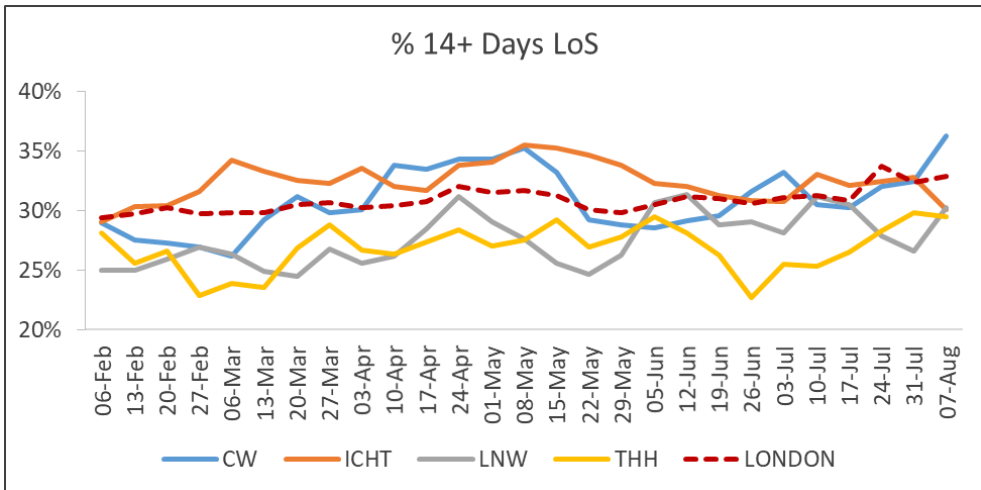
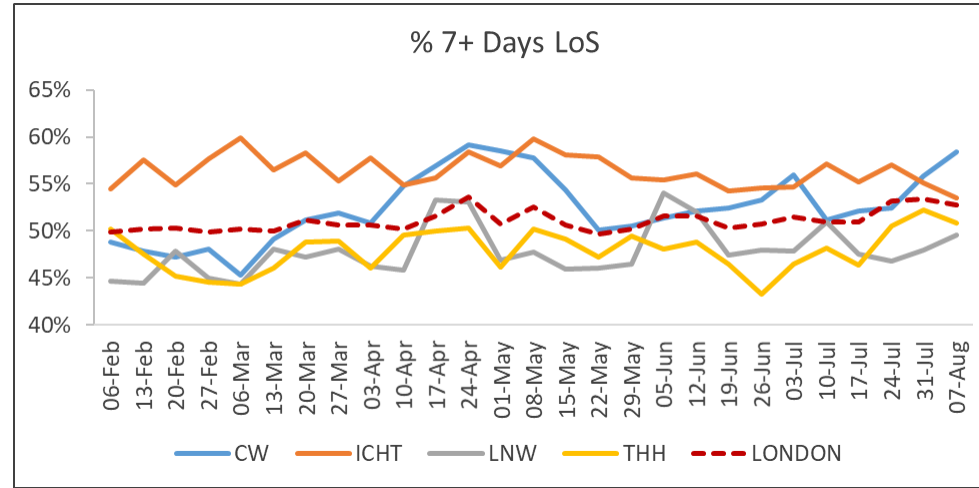
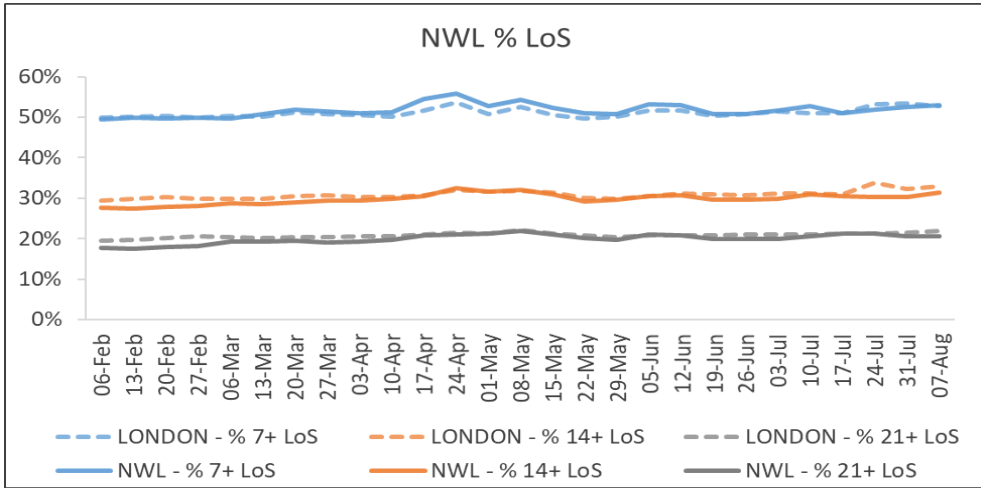
Latest data up to: 07/08/2022



Overview: ICS Summary – 7, 14 and 21 days length of stay

Source: UEC SitRep

Latest data up to: 07/08/2022



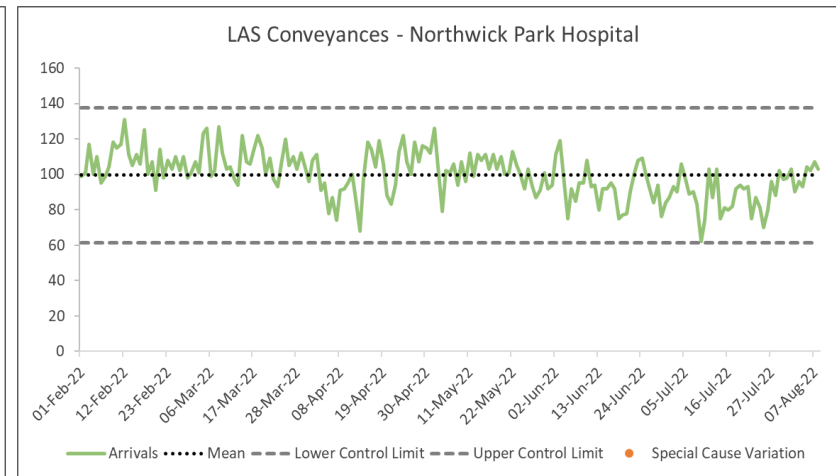
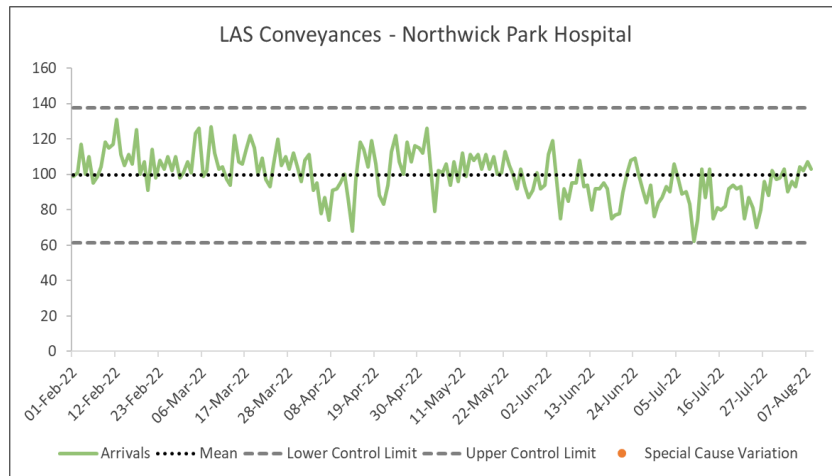
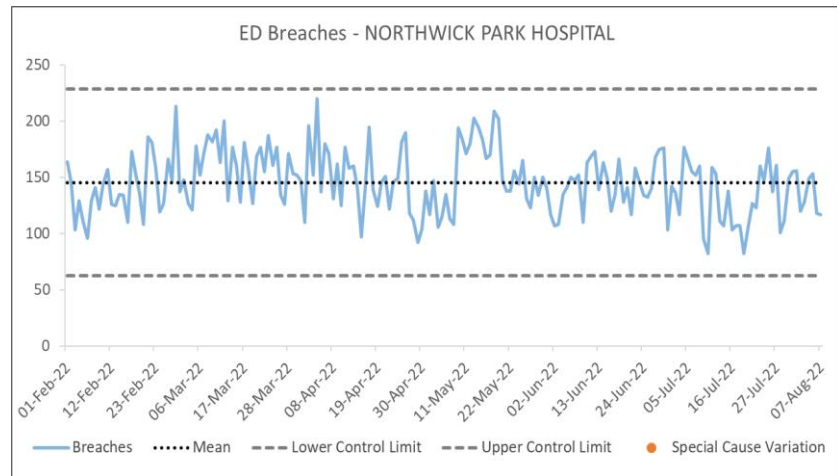
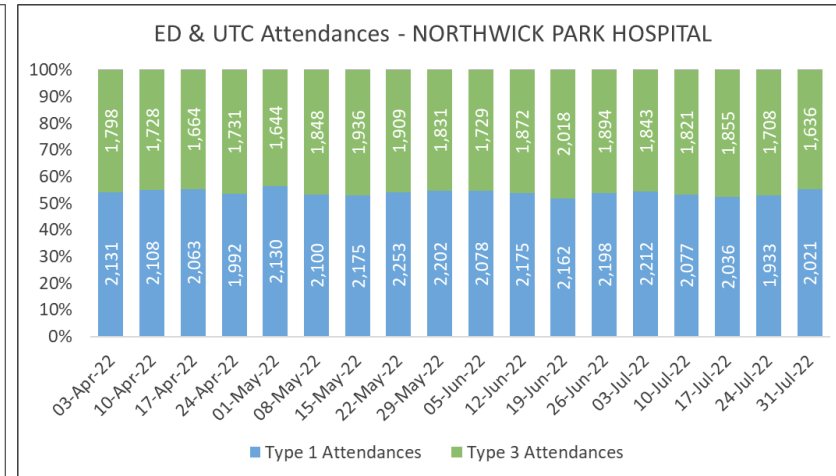
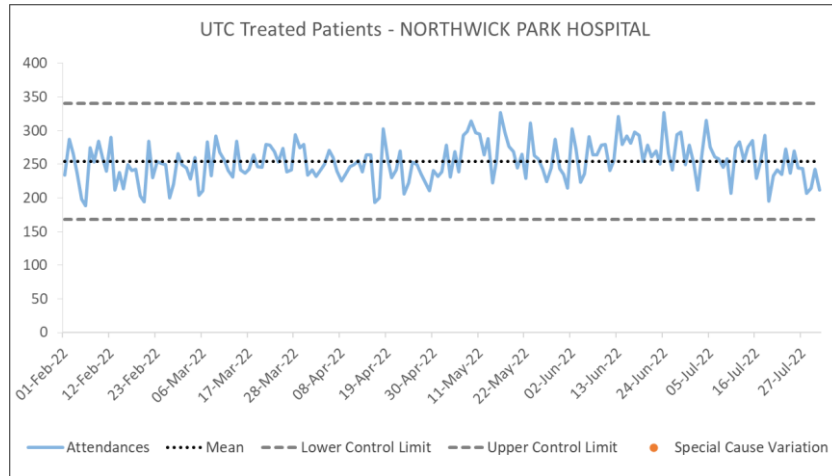
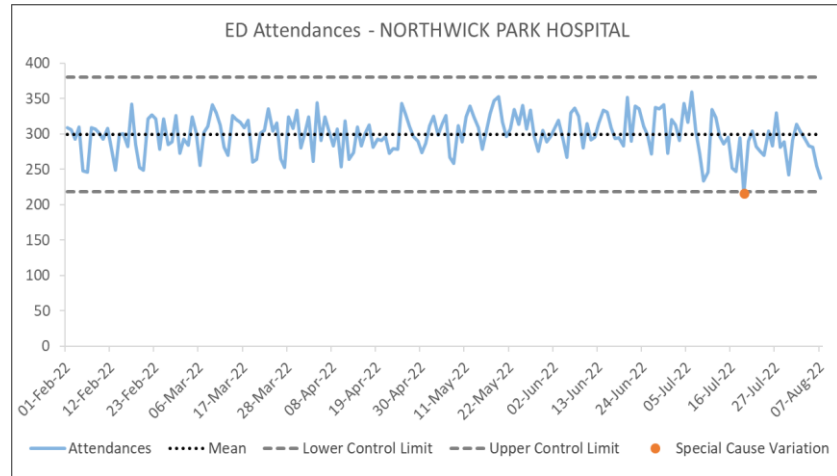
Highlights

- NWL performance is close to the regional average
- C&W Length of Stay has reduced following an increase in April across all metrics
- ICHT remains over the London average on all measures but has stabilised or reduced

Northwick Park Hospital – Front Door and LAS

Source: UEC SitRep, Totally SitRep, LAS Server

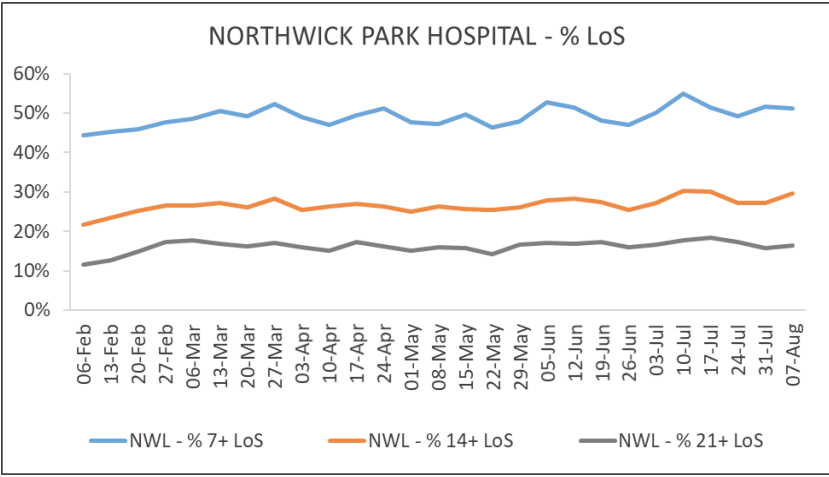
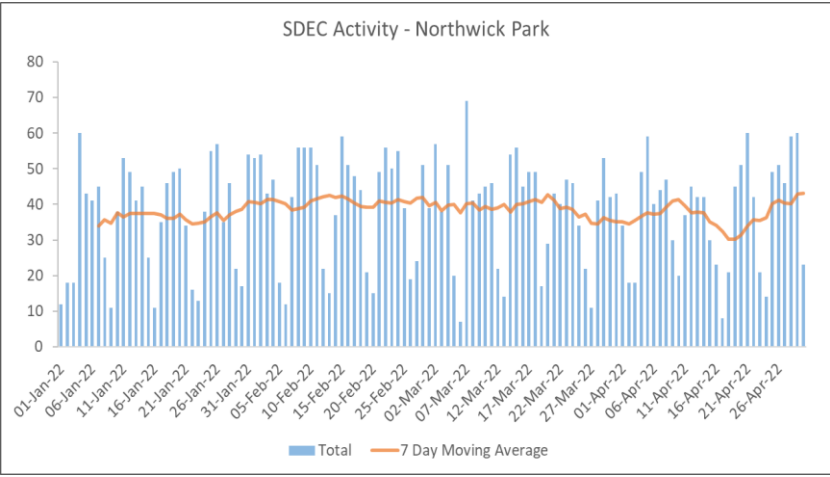
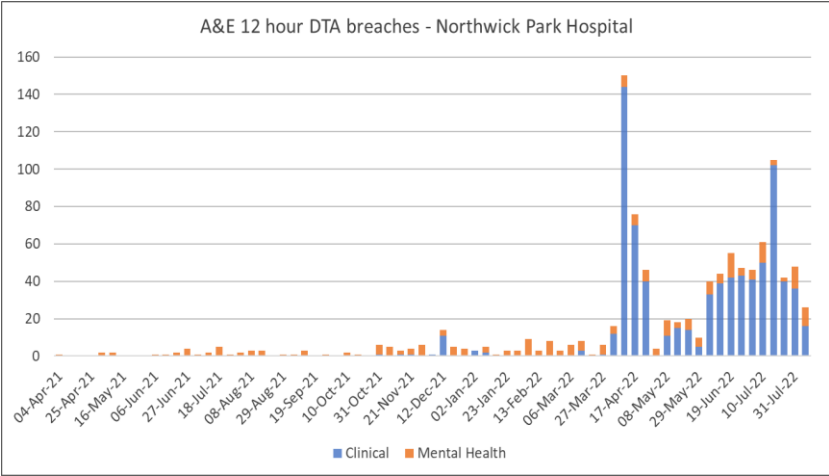
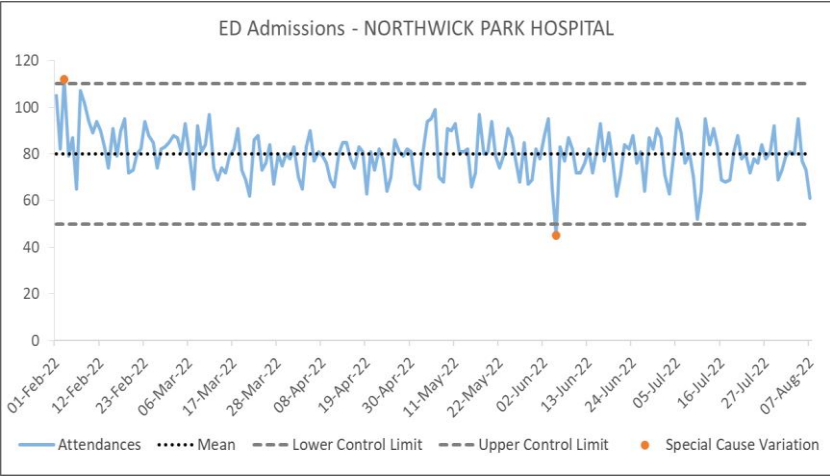
Latest data up to: 07/08/2022



Northwick Park Hospital – Admissions and Discharge

Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022

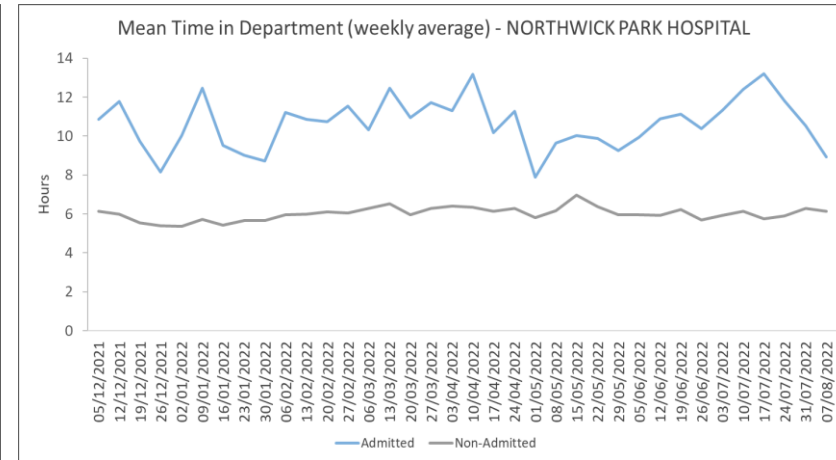
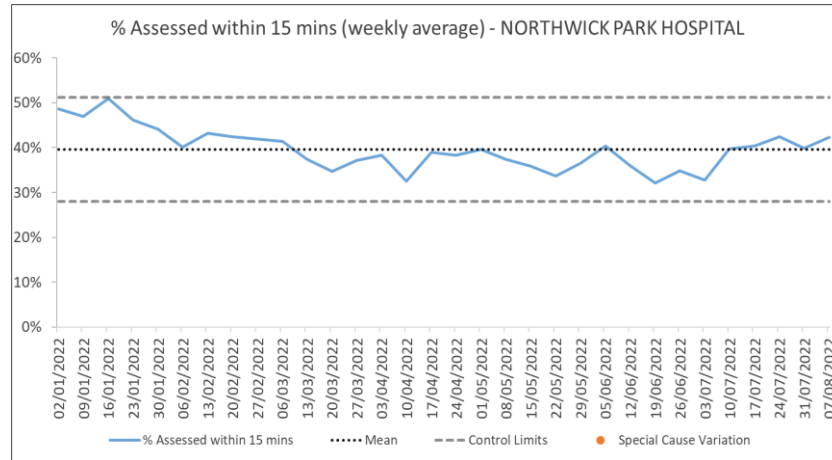
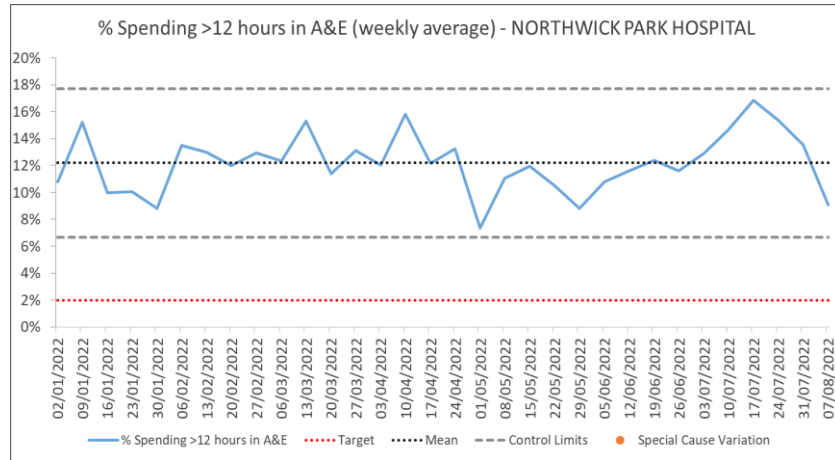


- DQ: Potential change by LNW in reporting for A&E 12 hour DTA breaches being investigated from 10/04/2022.
- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

Northwick Park – ECDS metrics

Source: ECDS

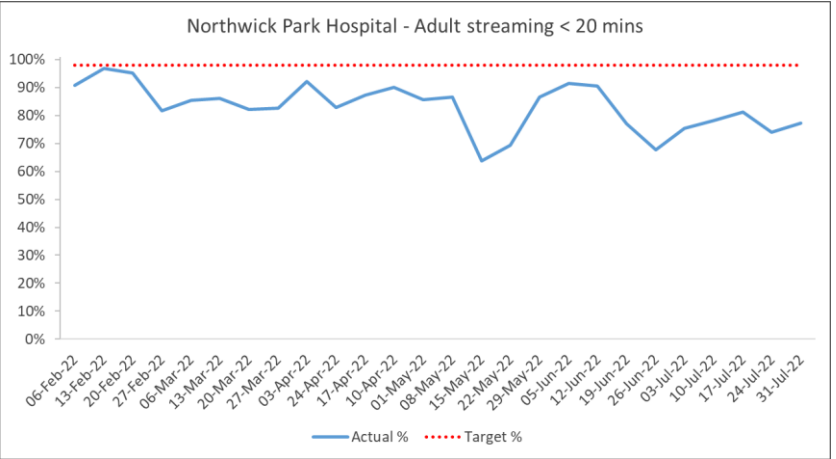
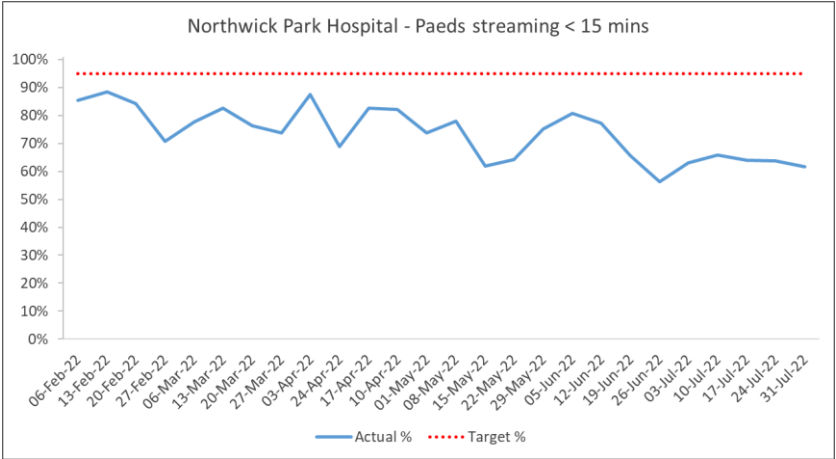
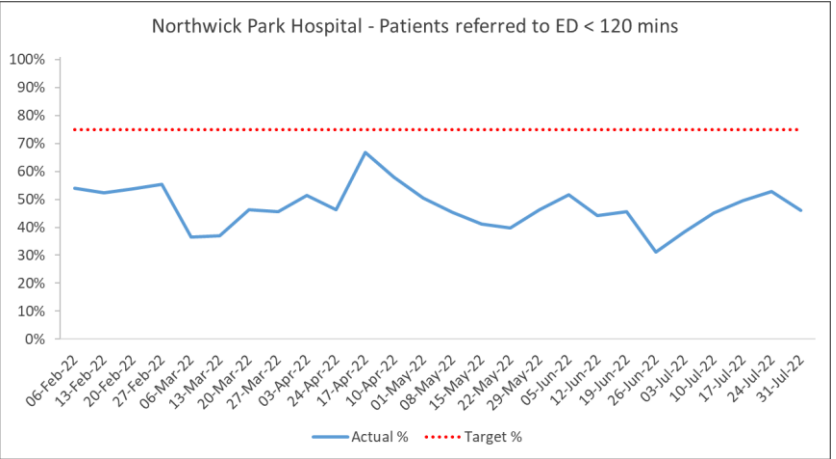
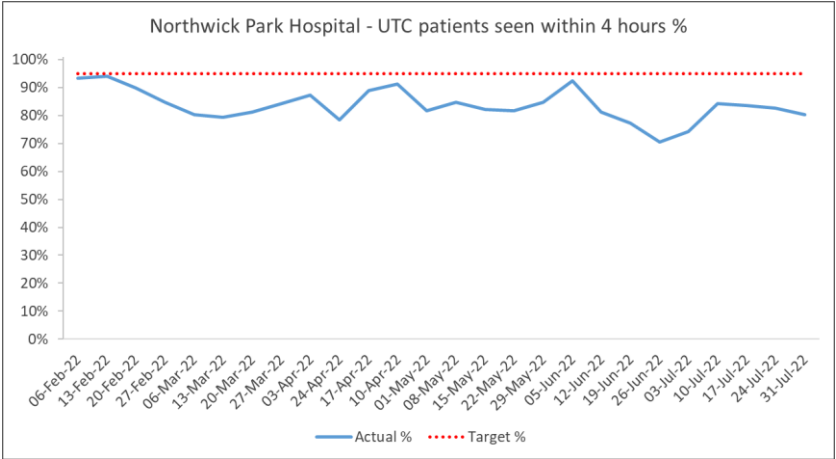
Latest data up to: 07/08/2022



Northwick Park Hospital – UTC

Source: Totally SitRep

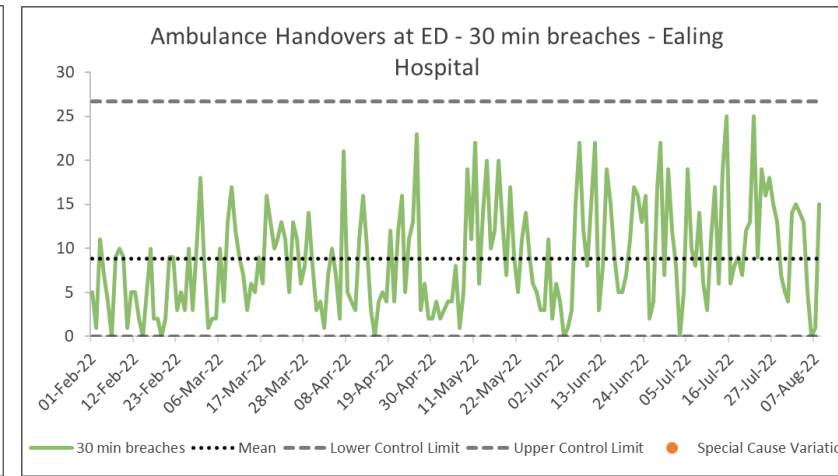
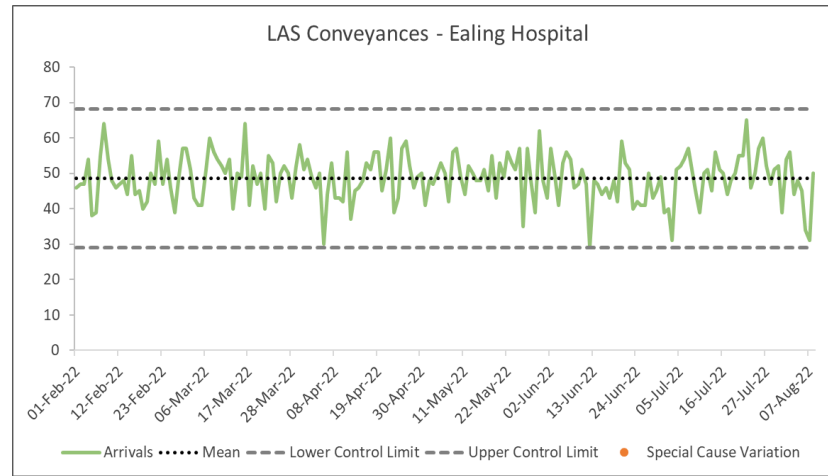
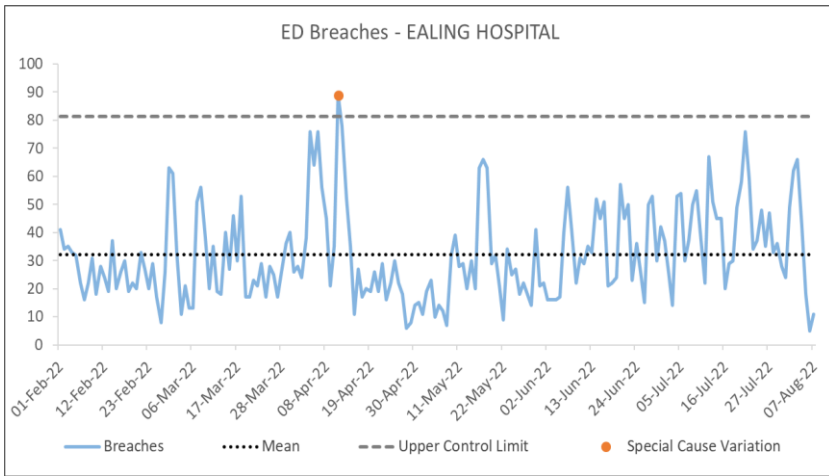
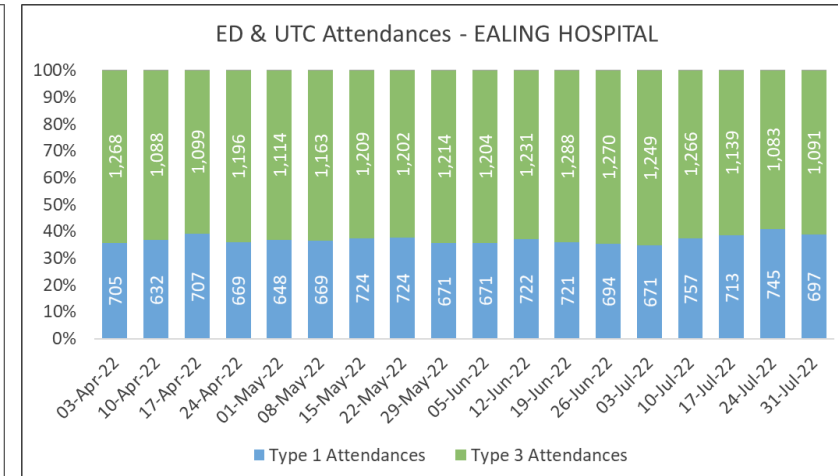
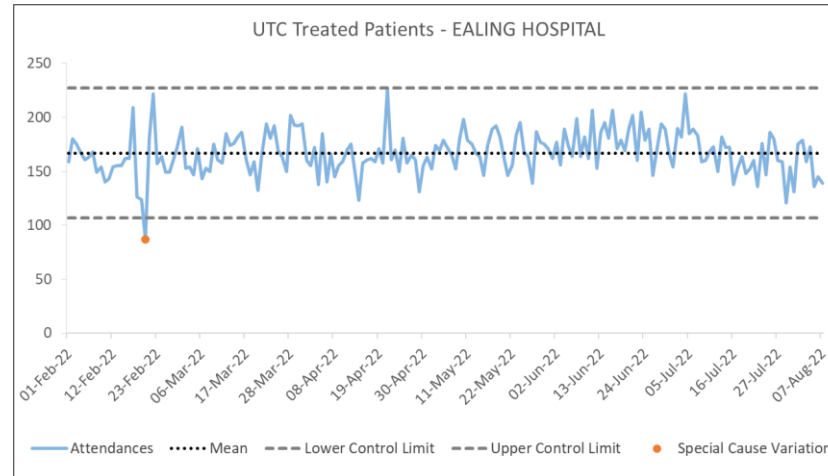
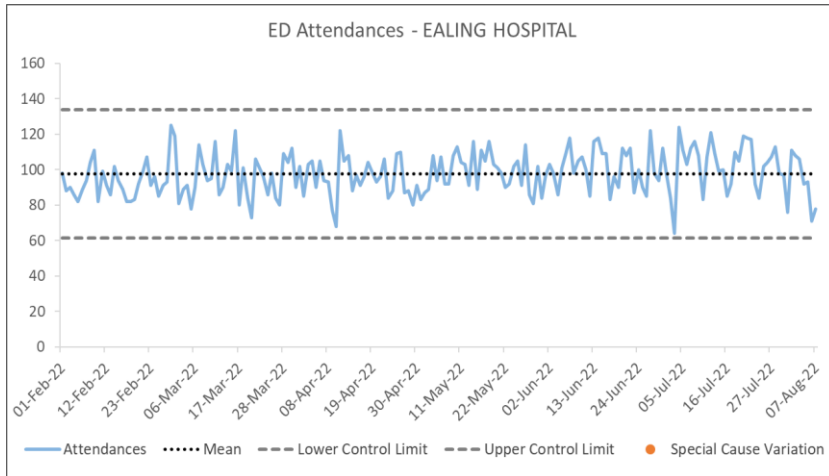
Latest data up to: 31/07/2022



Ealing Hospital – Front Door and LAS

Source: UEC SitRep, Totally SitRep, LAS Server

Latest data up to: 07/08/2022

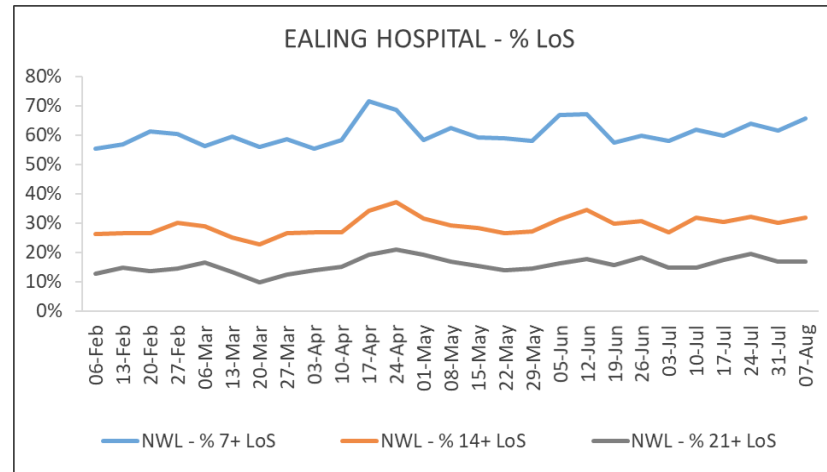
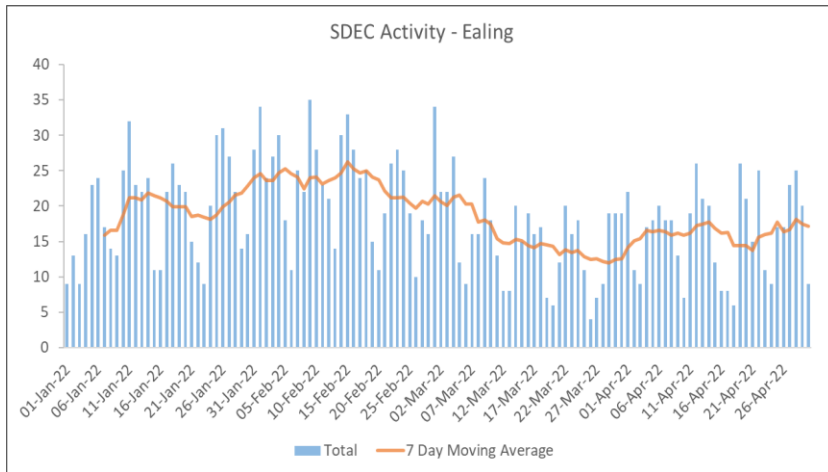
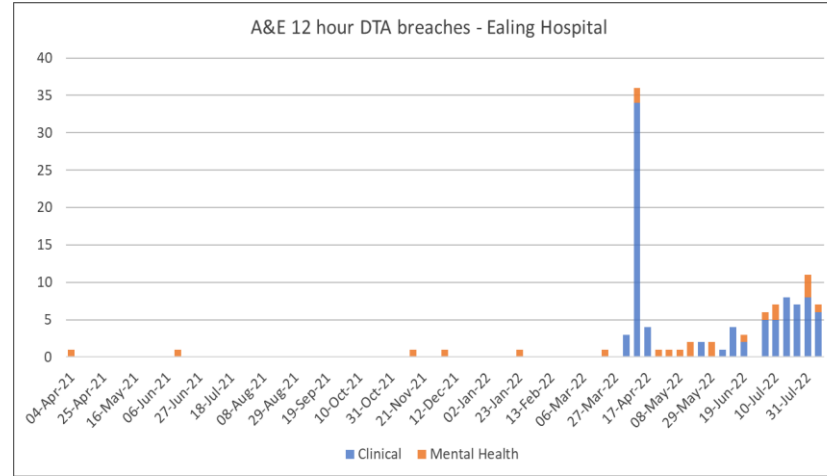
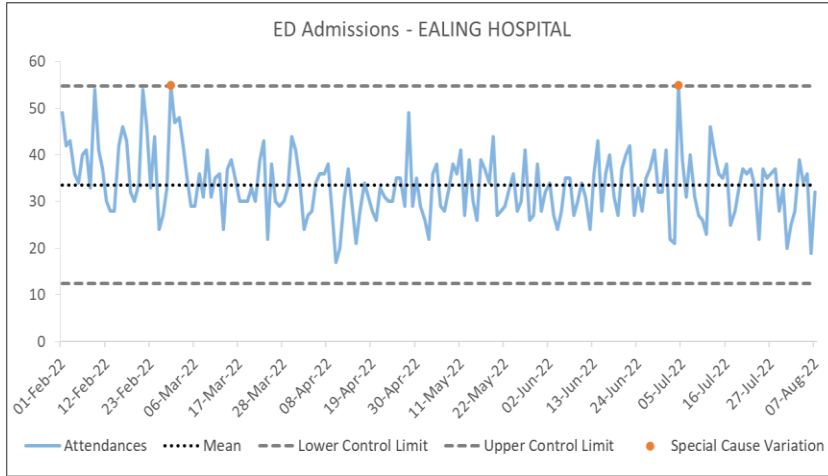


Potential for more balance between NPH and Ealing for conveyances though handover waits remain an issue

Ealing Hospital – Admissions and Discharges

Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022

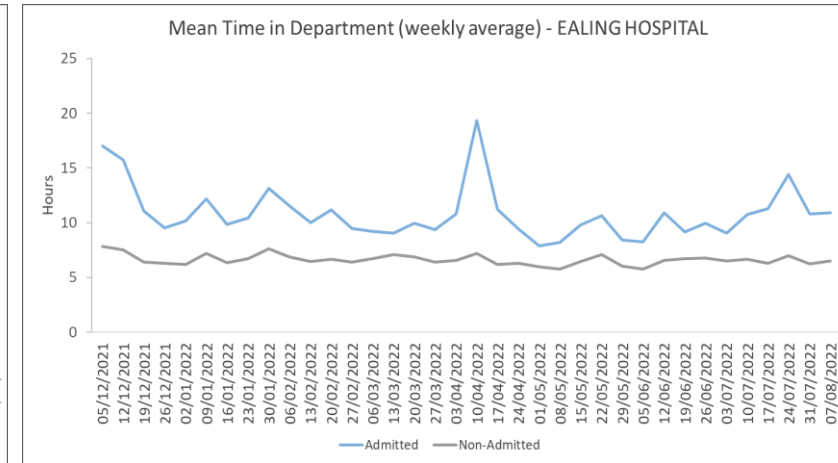
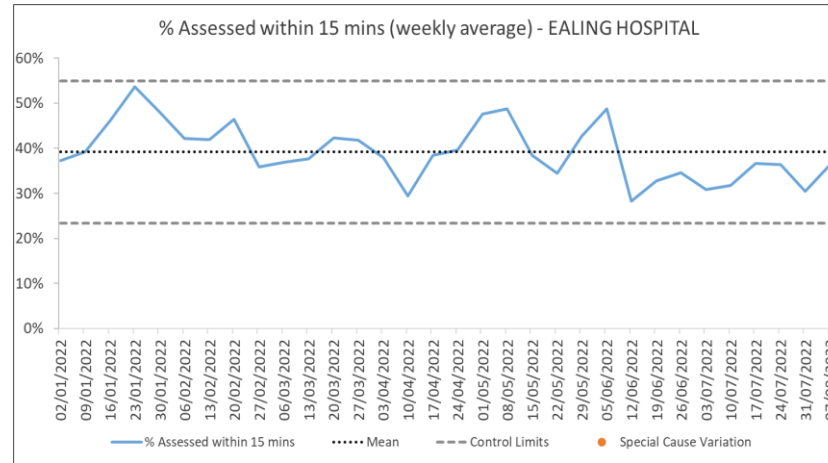
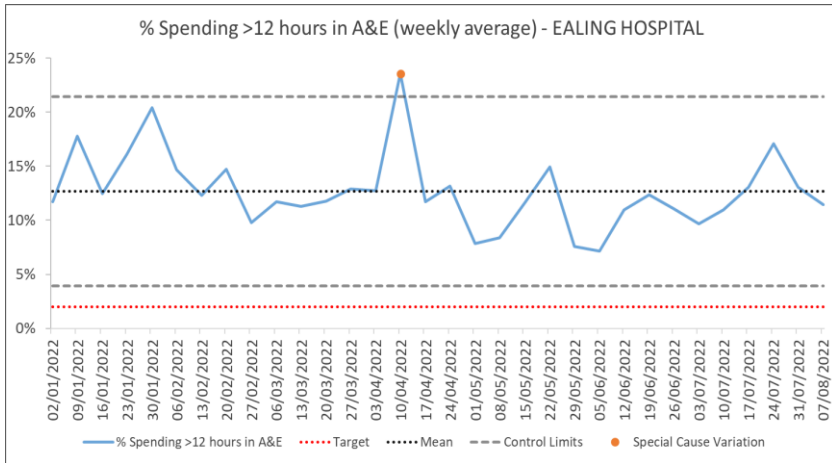


- DQ: Potential change by LNW in reporting for A&E 12 hour DTA breaches being investigated from 10/04/2022.
- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

Ealing Hospital – ECDS metrics

Source: ECDS

Latest data up to: 07/08/2022

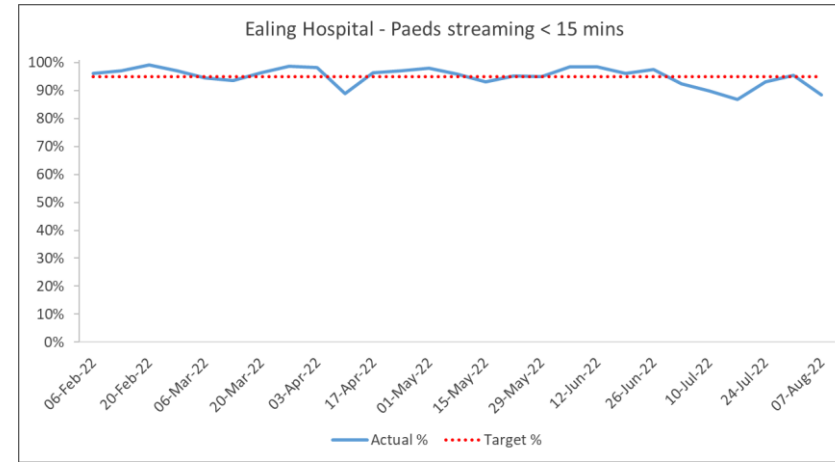
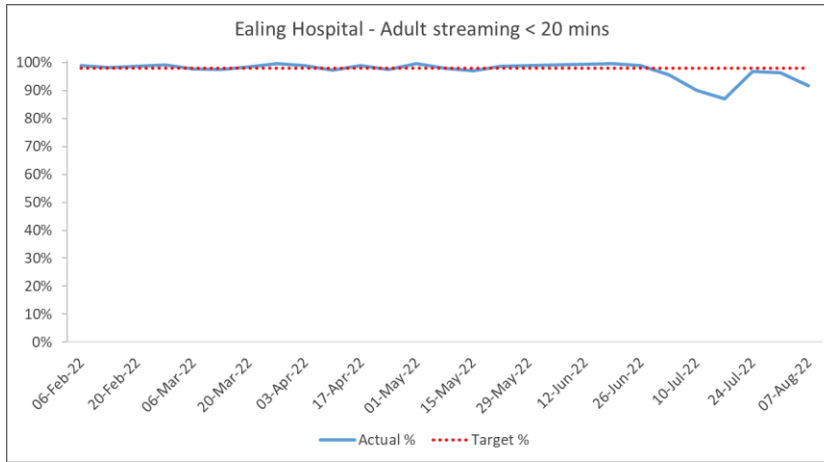
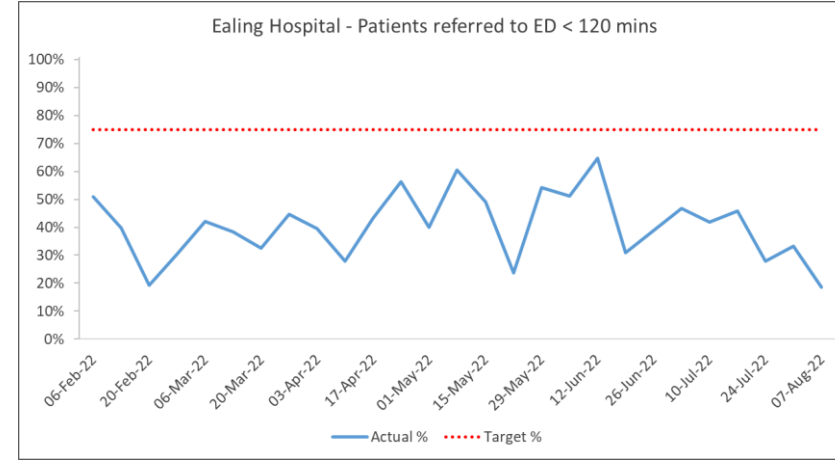
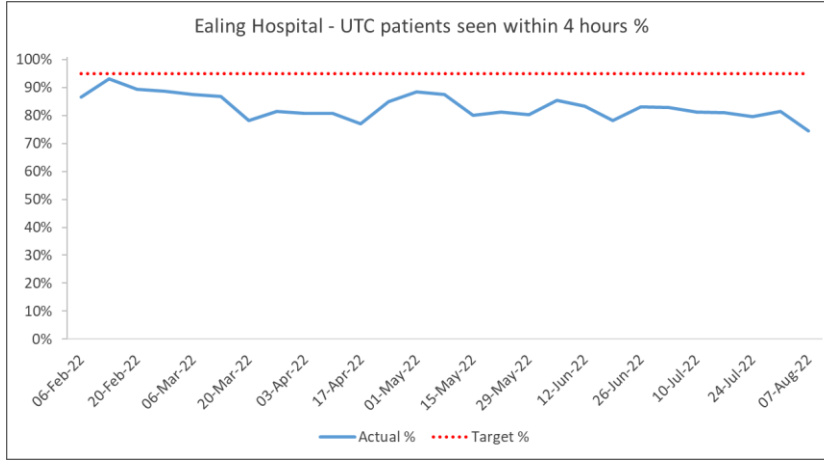


Time spent in ED has stabilised over the last month

Ealing Hospital – UTC

Source: Totally SitRep

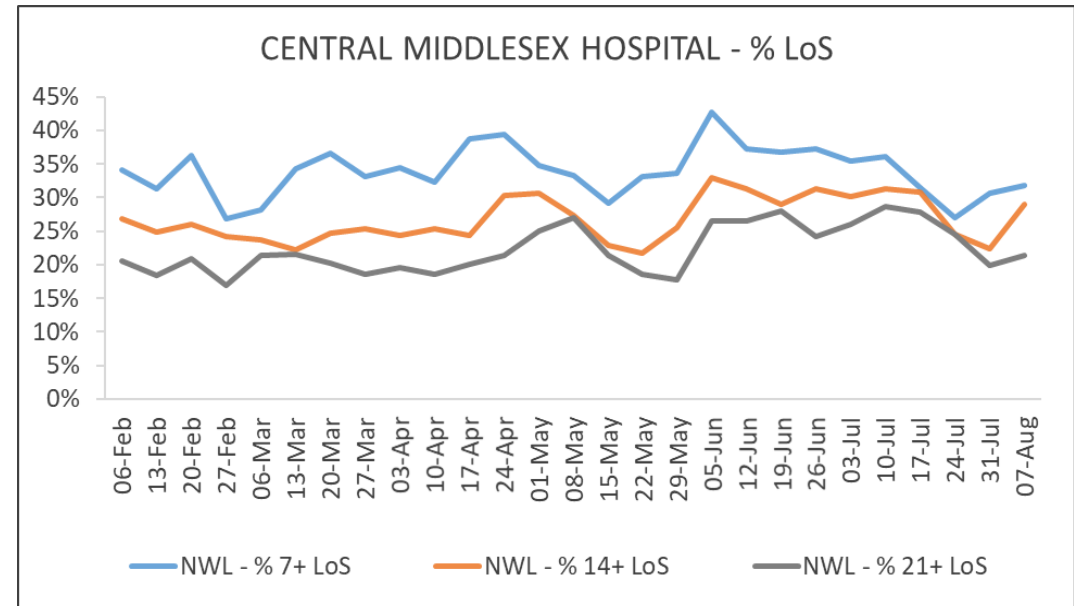
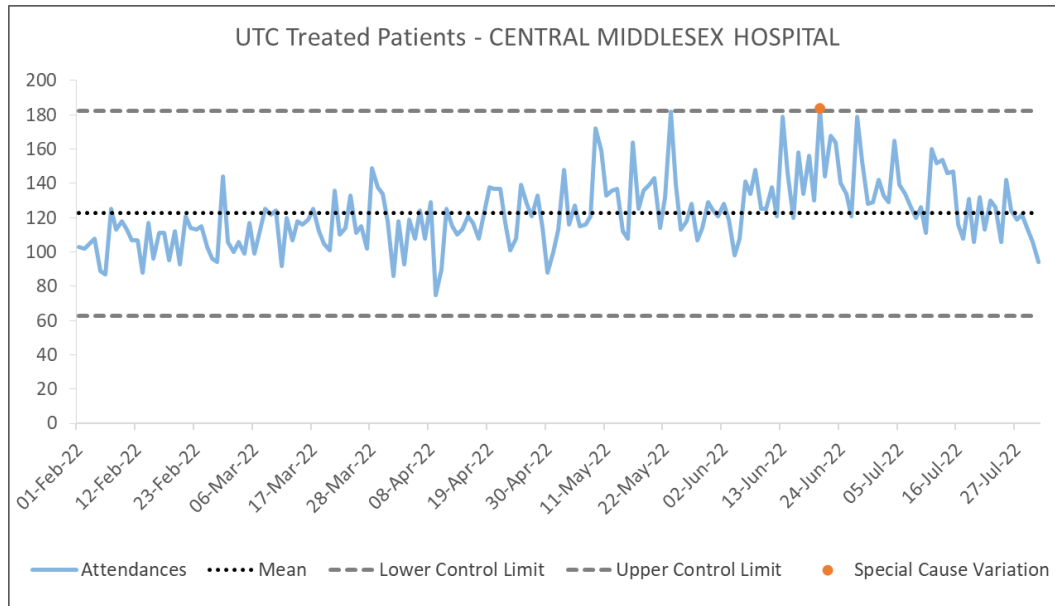
Latest data up to: 07/08/2022



Central Middlesex– UTC and LoS

Source: UEC SitRep, Totally SitRep, SUS

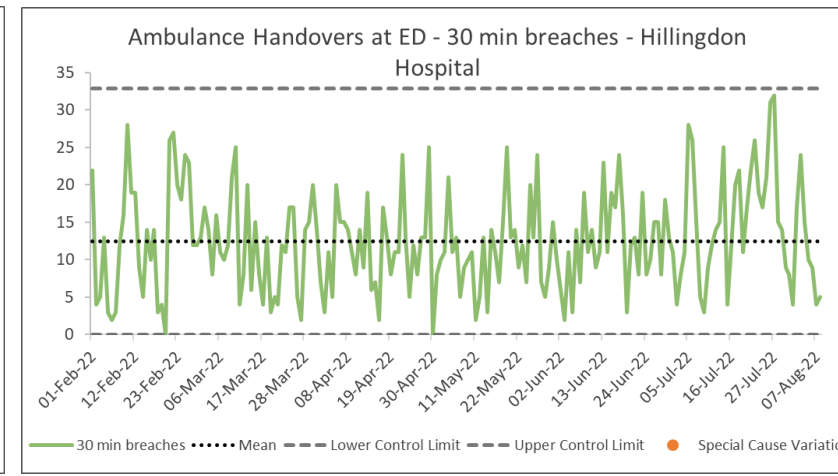
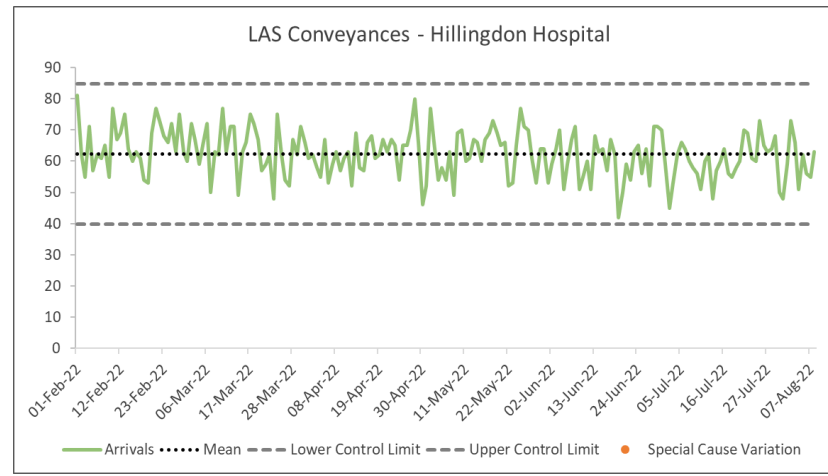
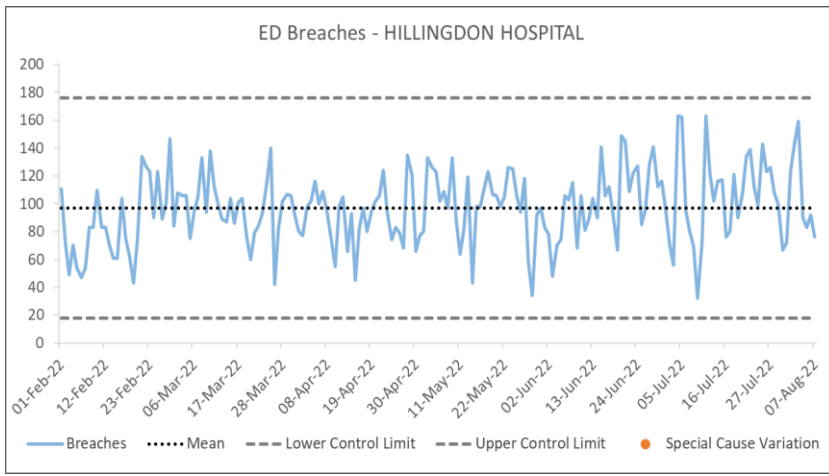
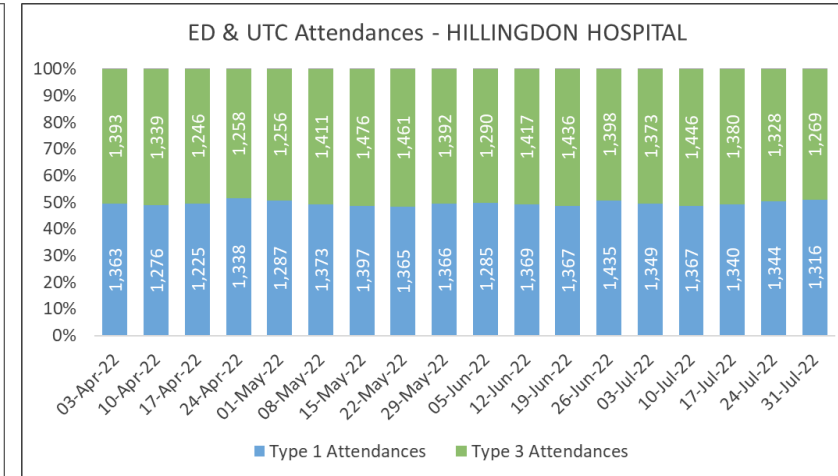
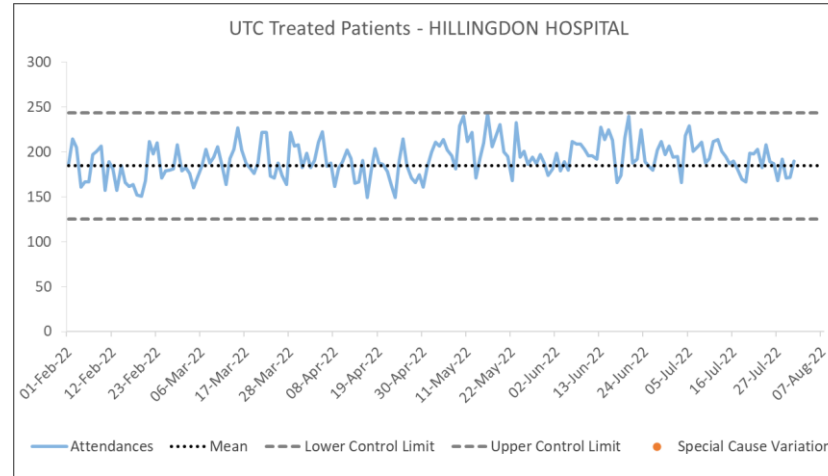
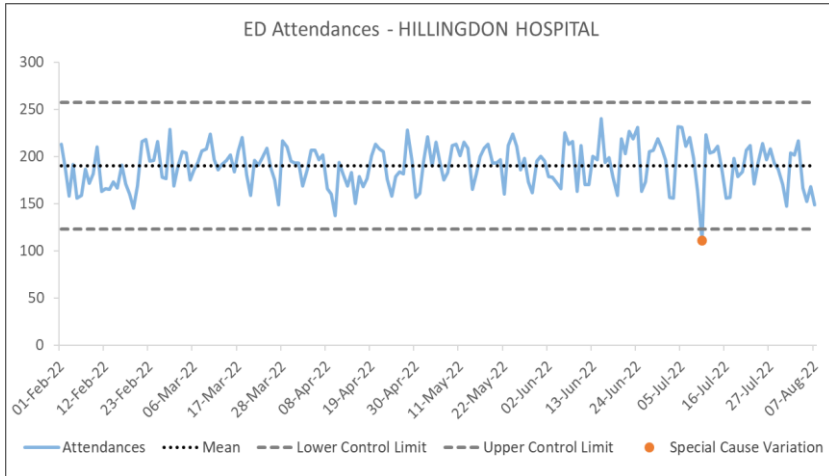
Latest data up to: 07/08/2022



The Hillingdon Hospital – Front Door and LAS

Source: UEC SitRep, Totally SitRep, LAS Server

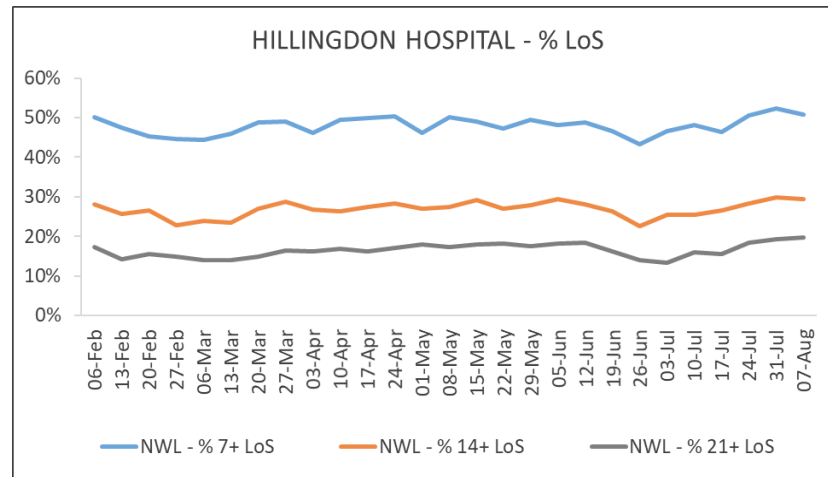
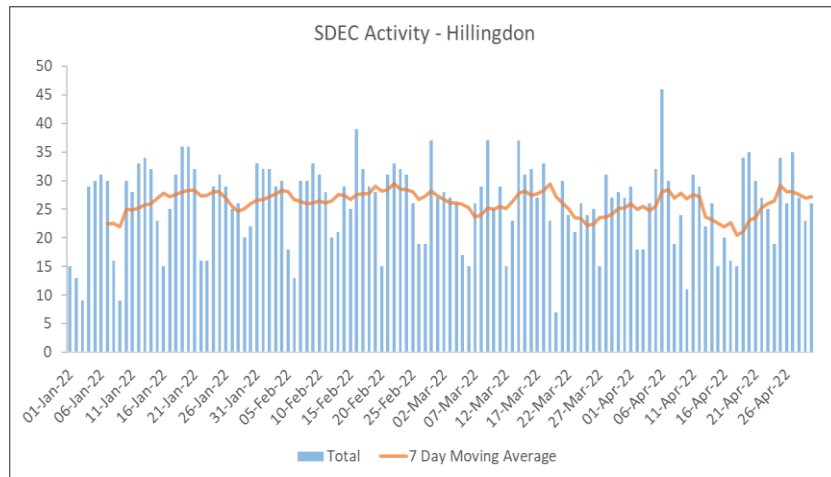
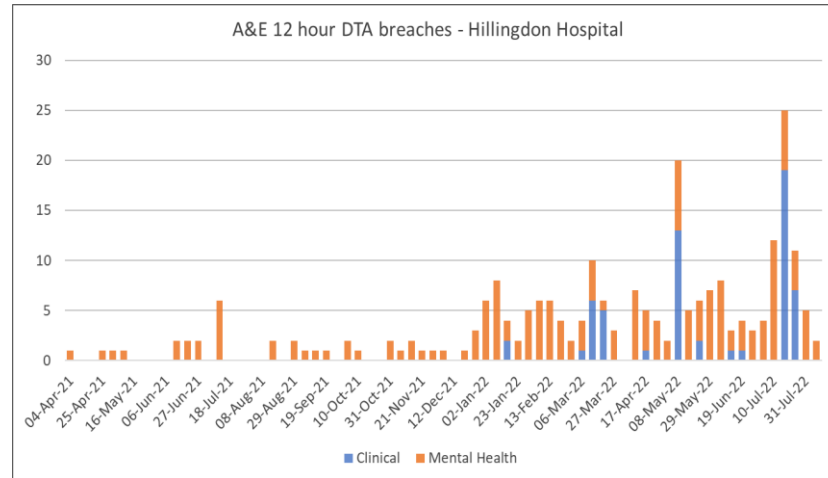
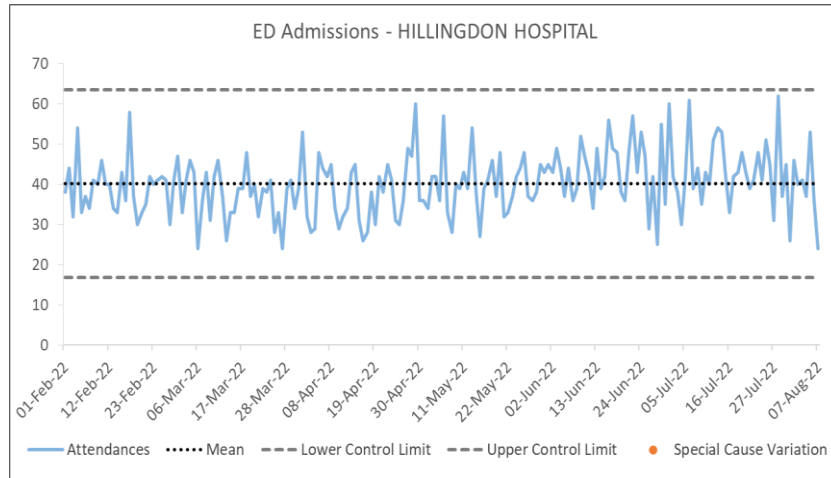
Latest data up to: 07/08/2022



The Hillingdon Hospital – Admissions and Discharges

Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022

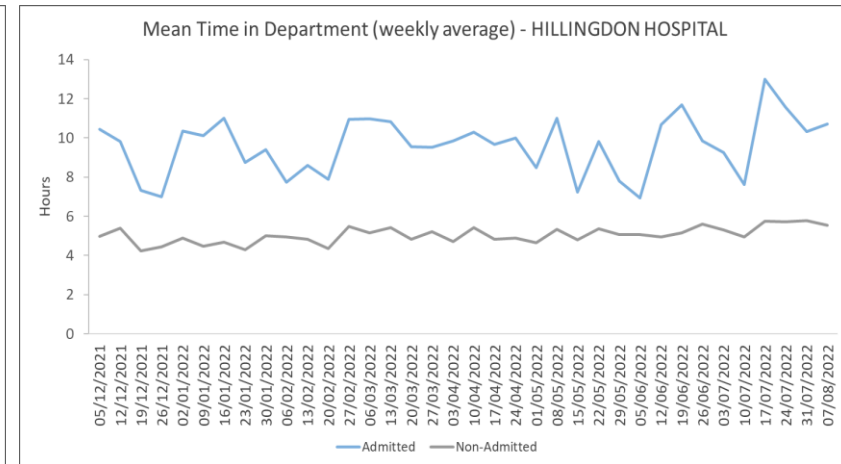
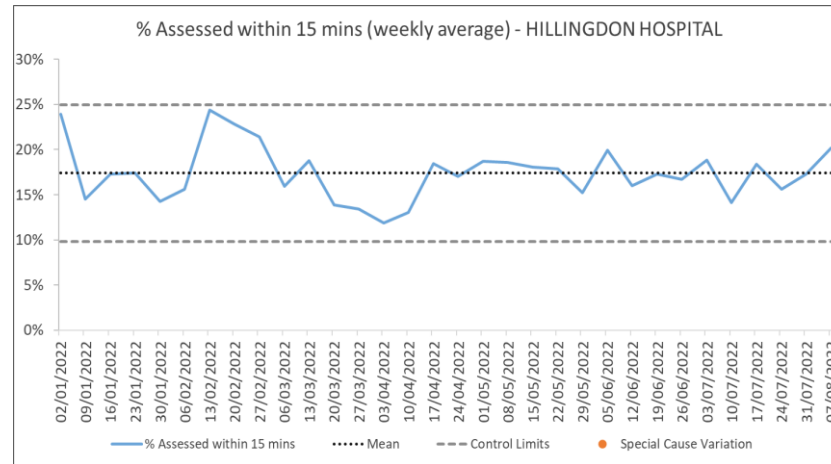
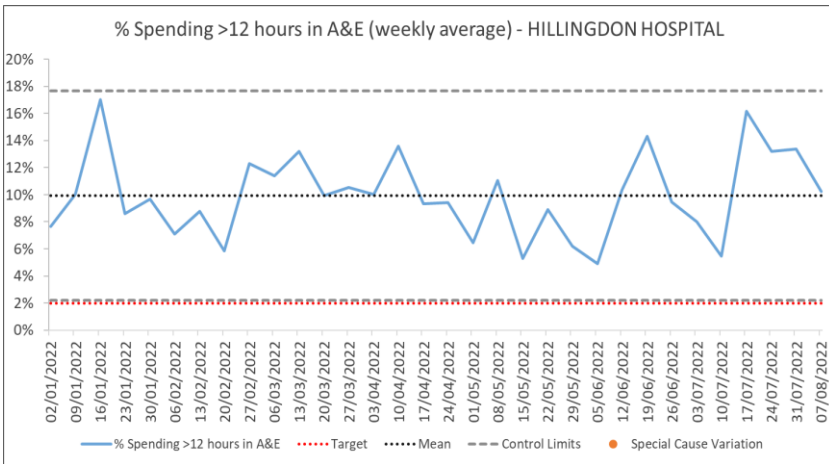


- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

Hillingdon – ECDS metrics

Source: ECDS

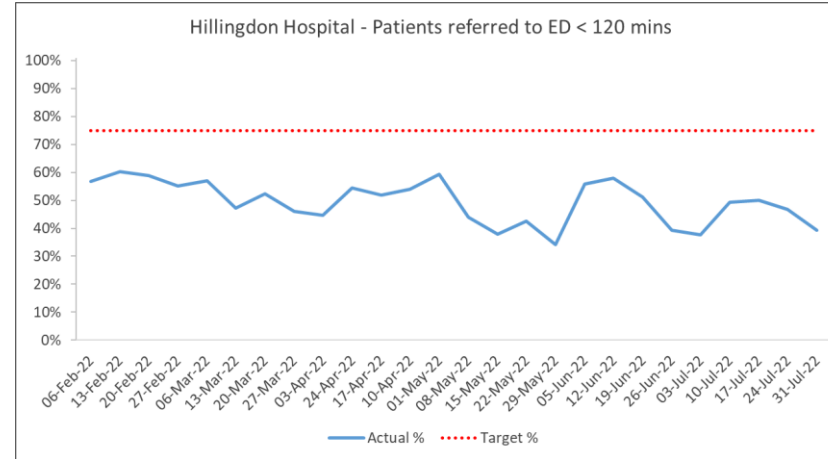
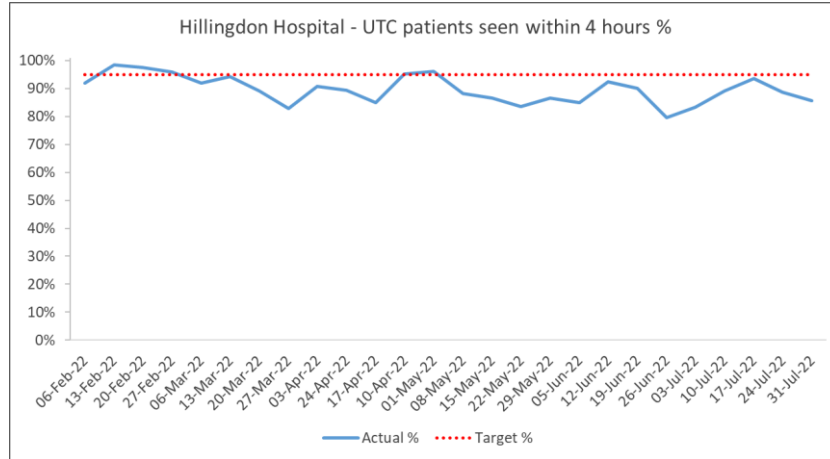
Latest data up to: 07/08/2022



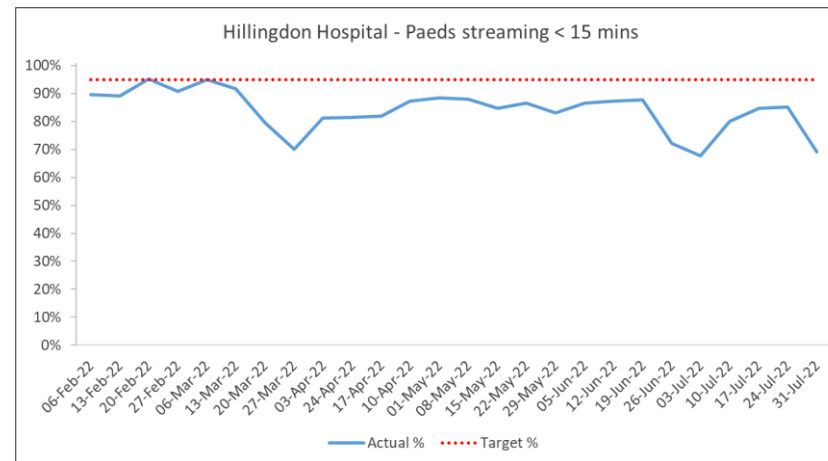
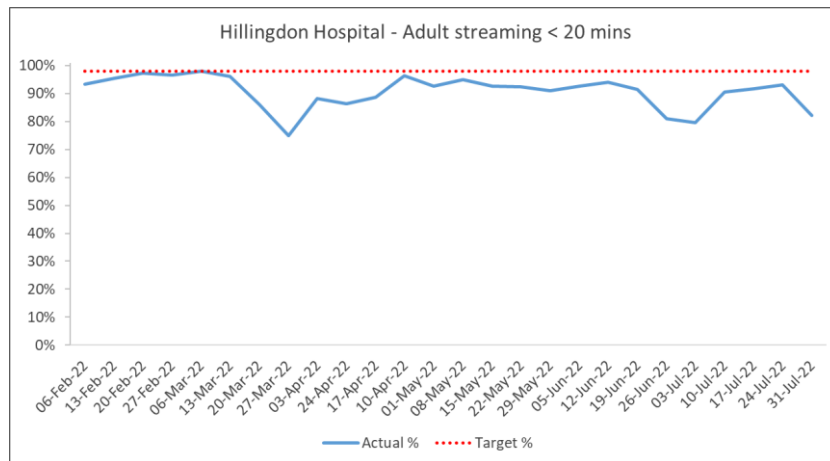
The Hillingdon Hospital – UTC

Source: Totally SitRep

Latest data up to: 07/08/2022



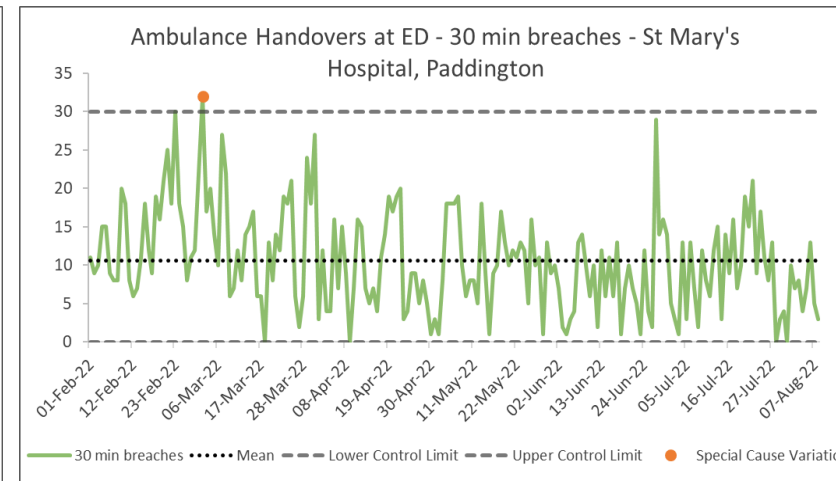
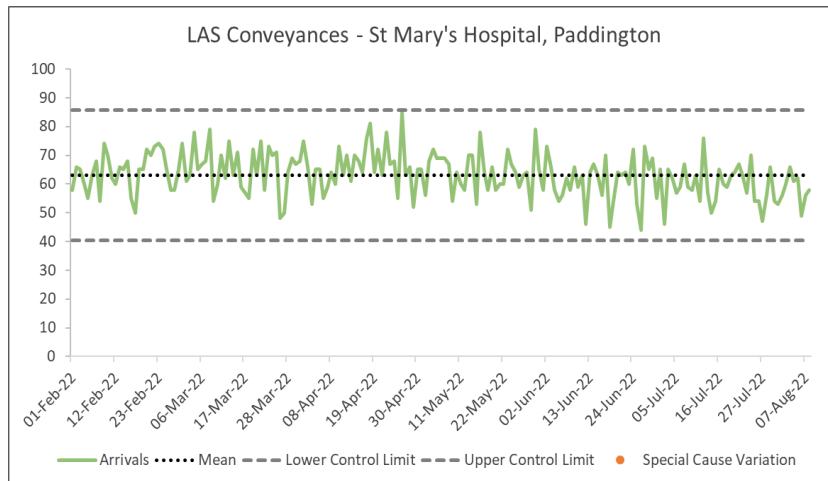
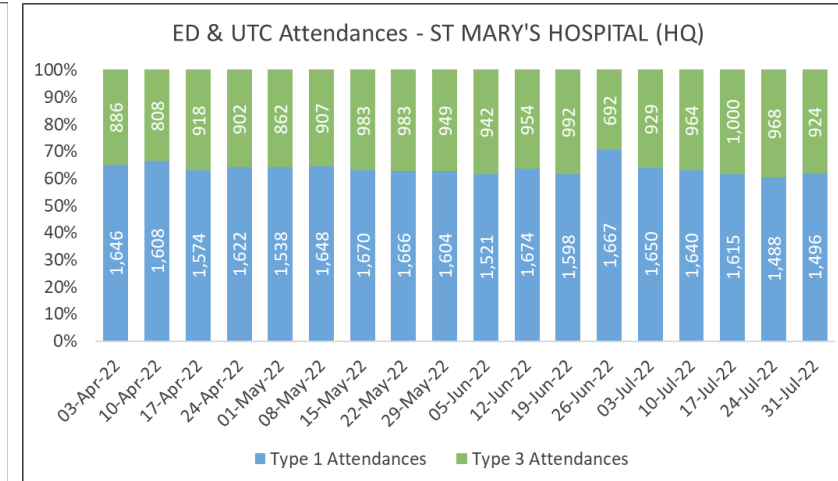
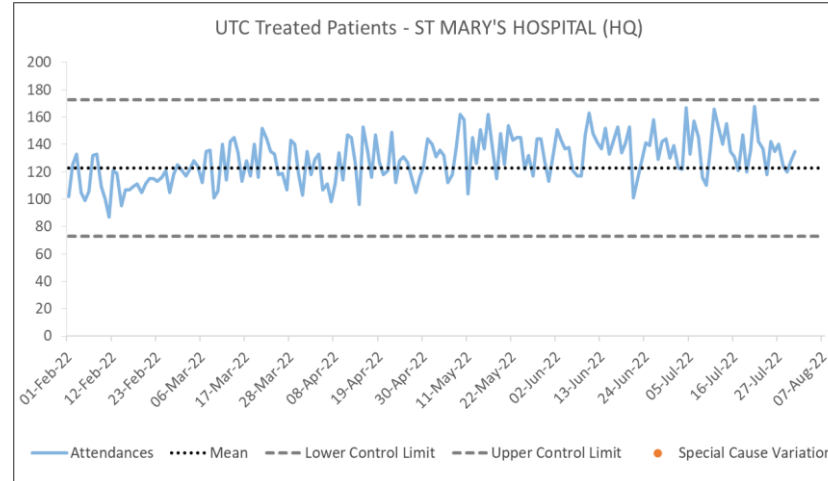
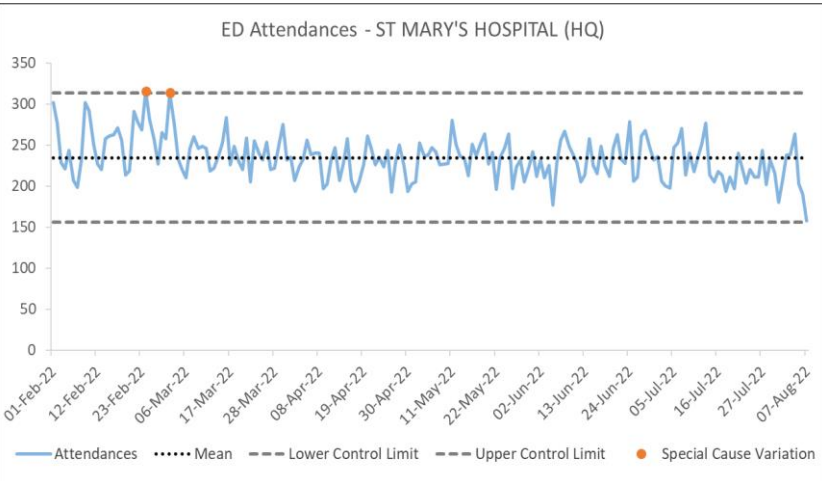
4 hour waits performance has hit the standard on occasion in the last two months but streaming is below target



St Mary's Hospital – A&E & UTC Performance and Capacity

Source: UEC SitRep, Totally SitRep, LAS Server

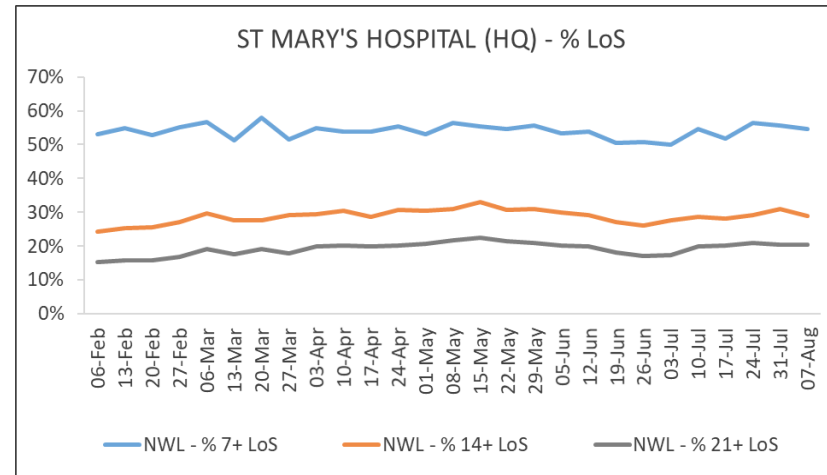
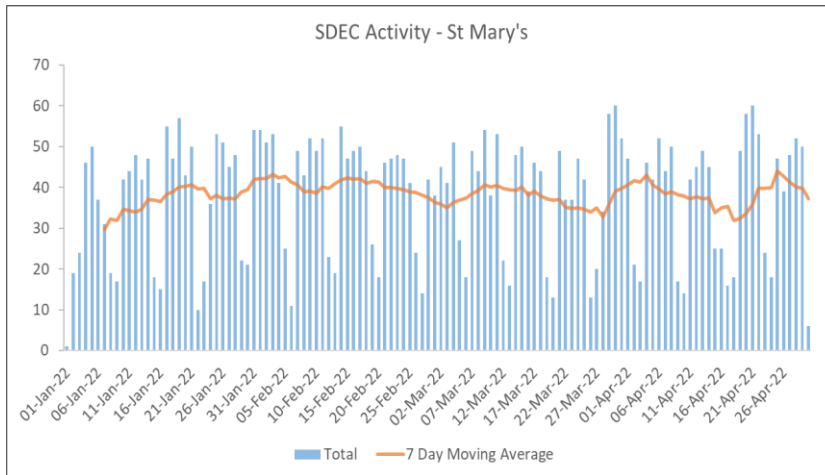
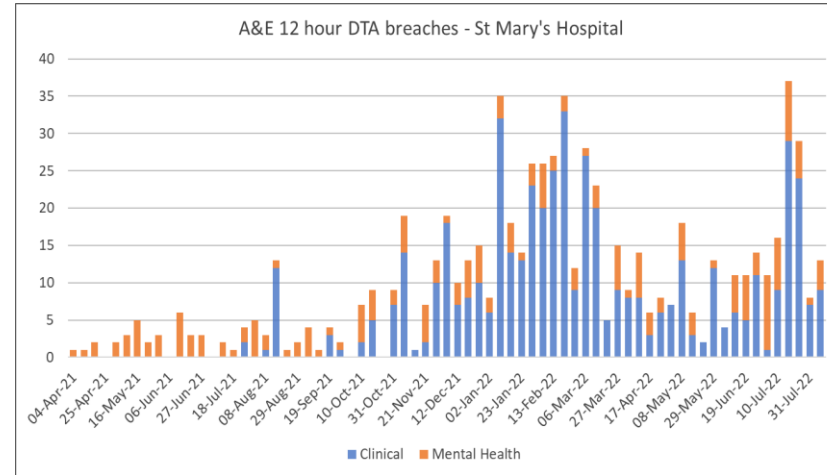
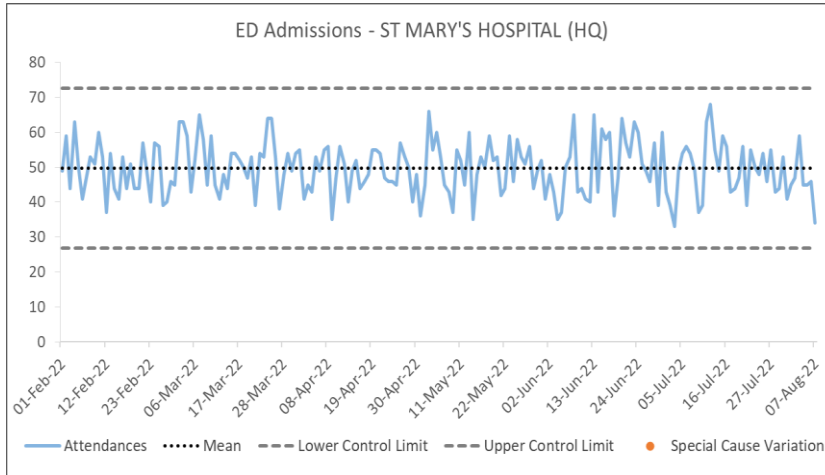
Latest data up to: 07/08/2022



St Mary's Hospital – Admissions and Discharges

Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022

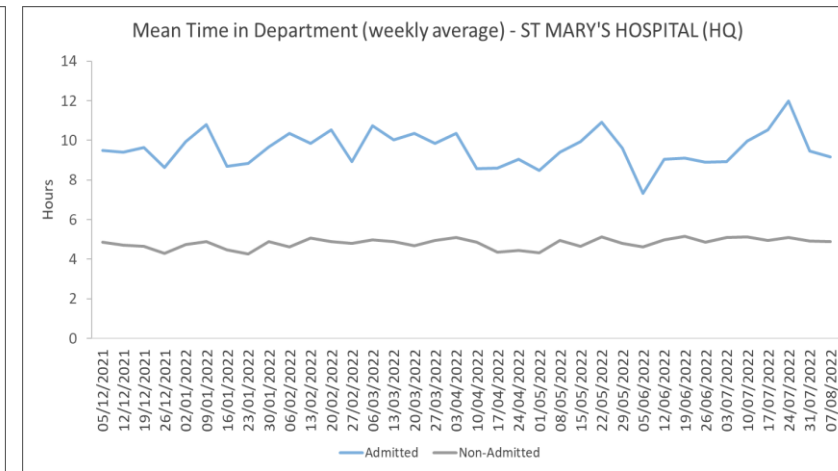
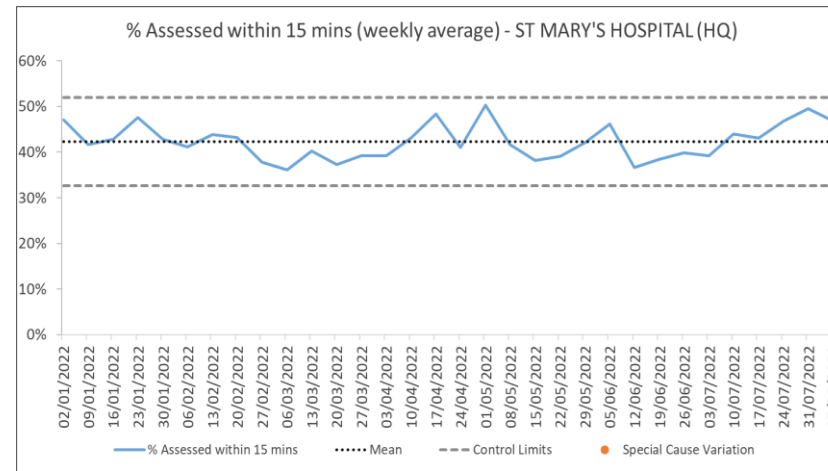
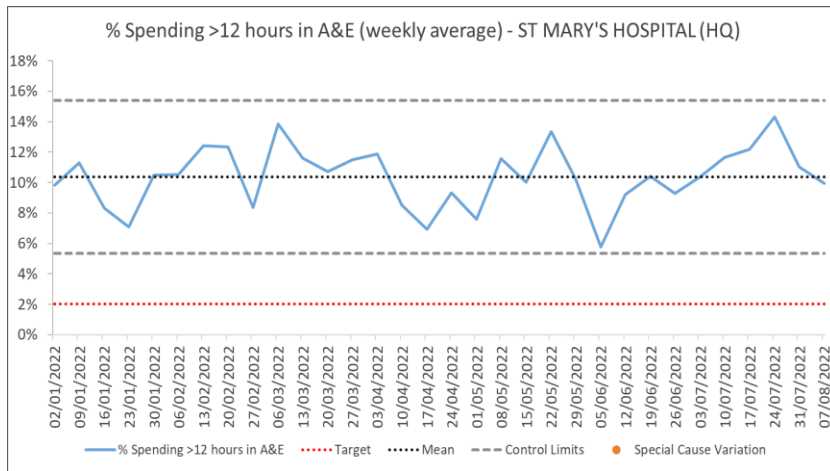


- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

St Mary's – ECDS metrics

Source: ECDS

Latest data up to: 07/08/2022

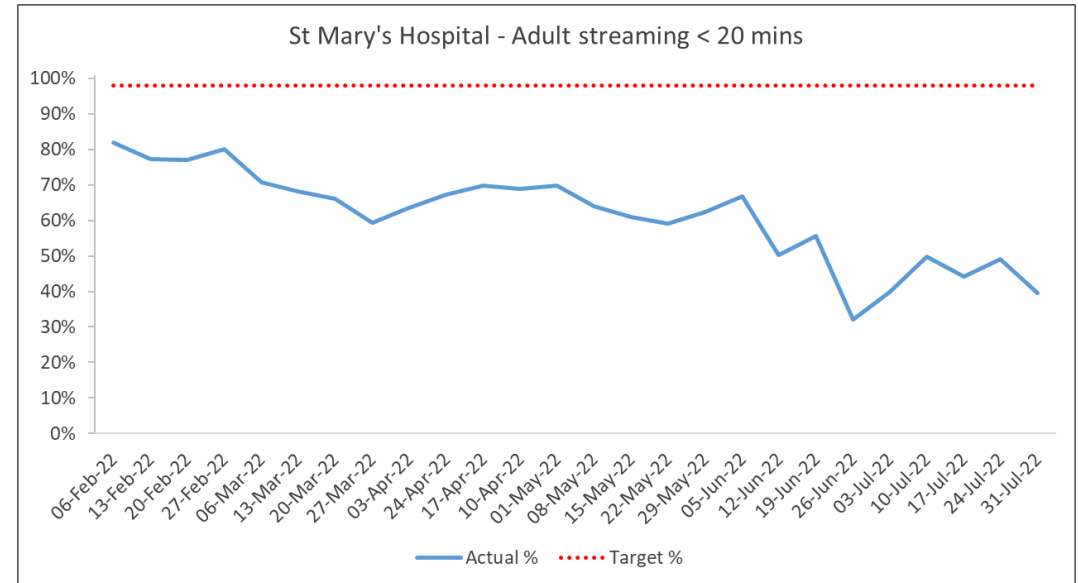
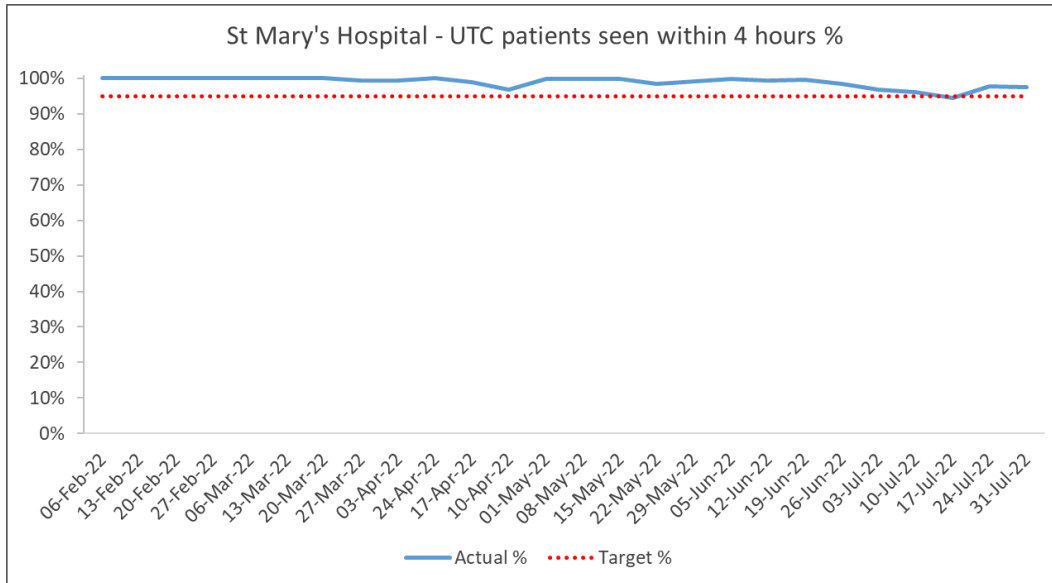


Streaming performance largely stable but below standard since ICHT took responsibility for the front door

St Mary's Hospital – UTC

Source: Totally SitRep

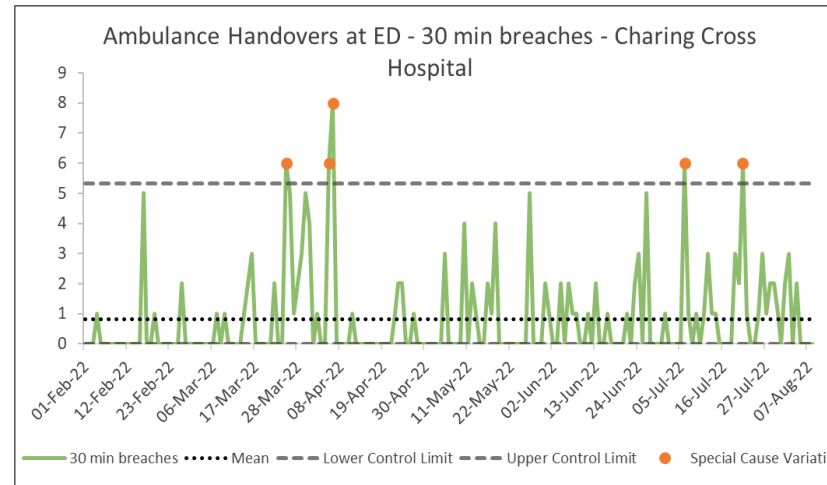
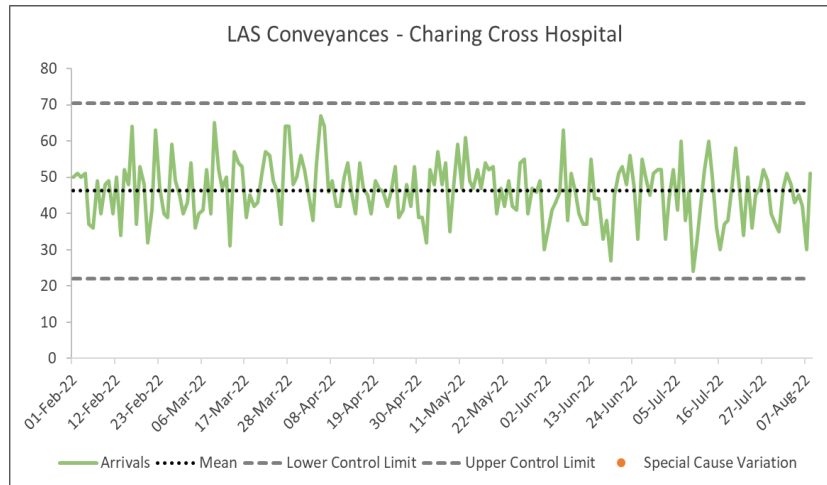
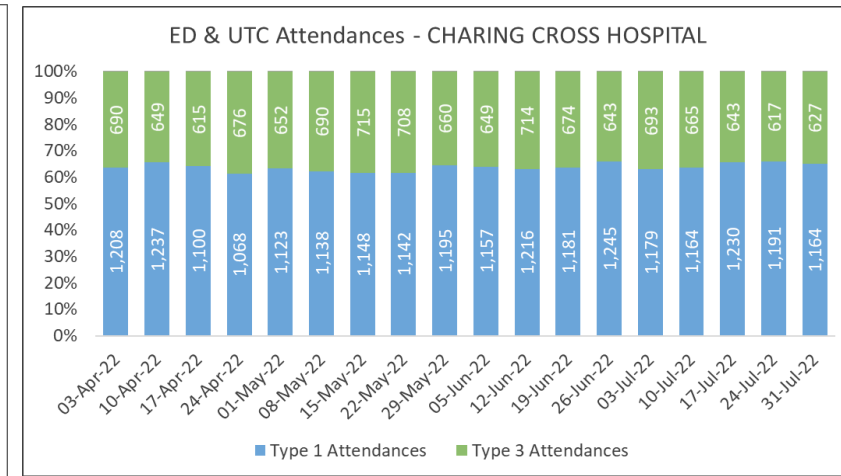
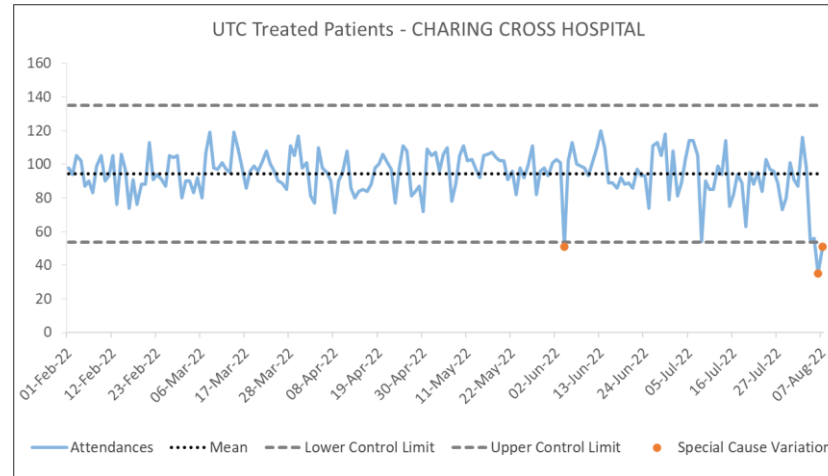
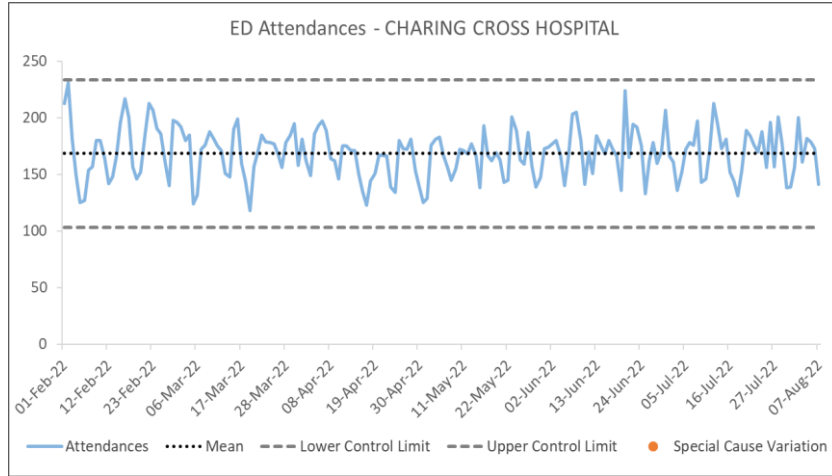
Latest data up to: 07/08/2022



Charing Cross Hospital – A&E & UTC Performance and Capacity

Source: UEC SitRep, Totally SitRep, LAS Server

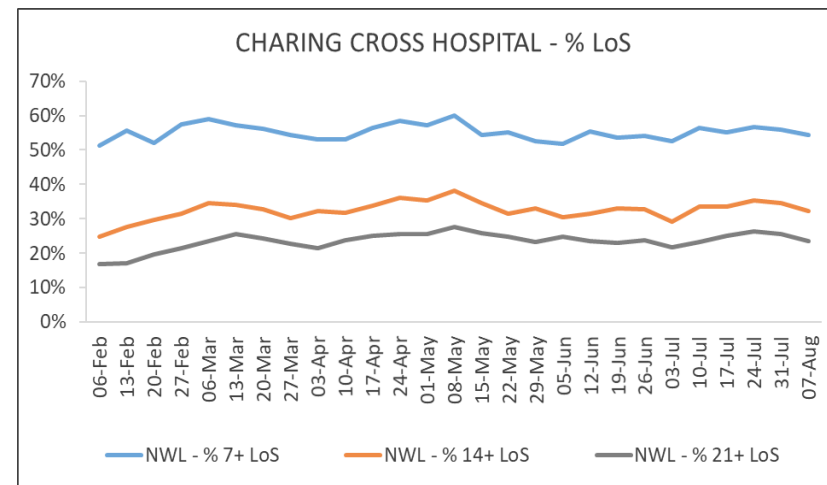
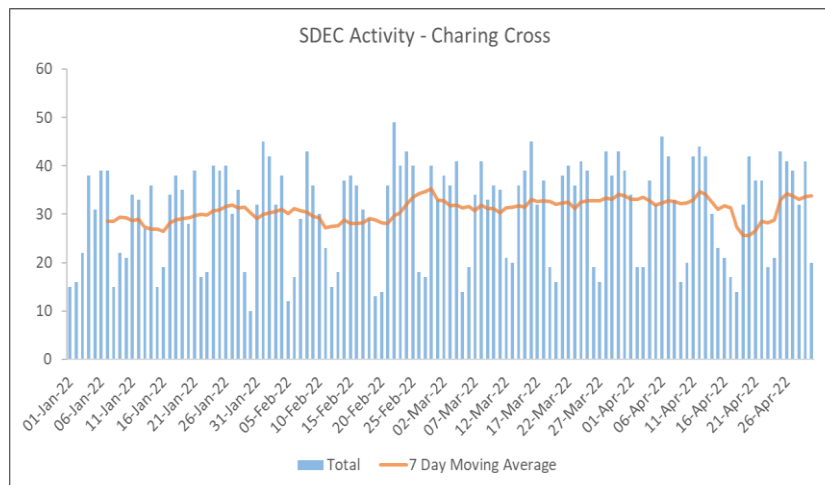
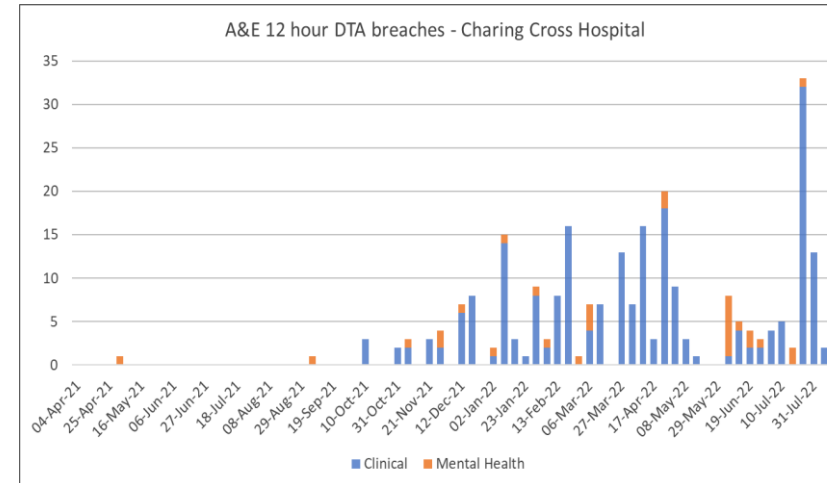
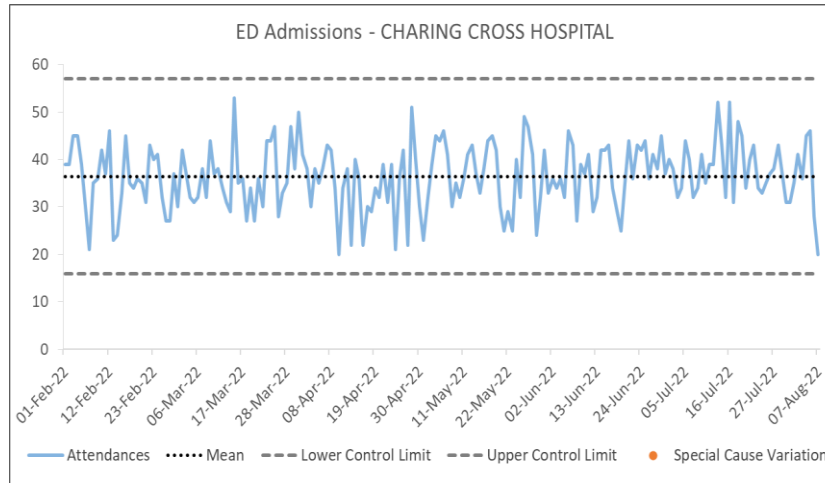
Latest data up to: 07/08/2022



Charing Cross Hospital – Admissions and Discharges

Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022

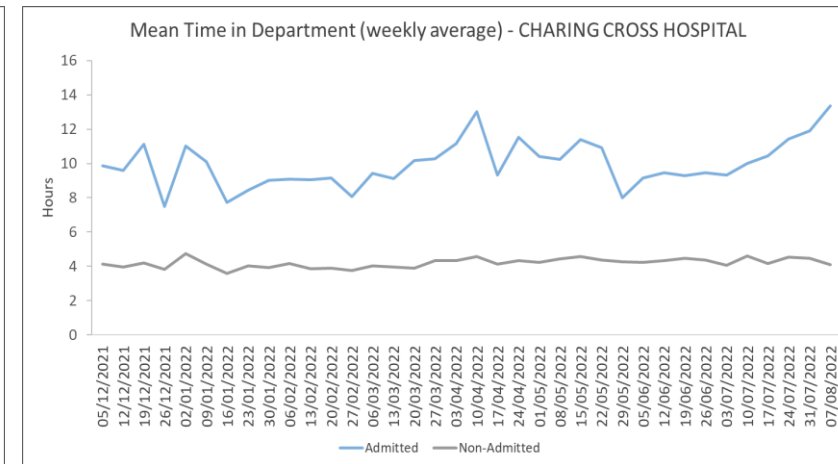
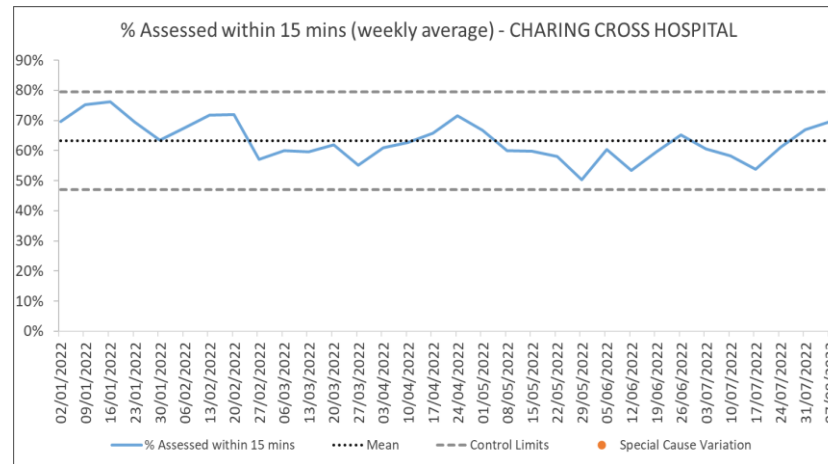
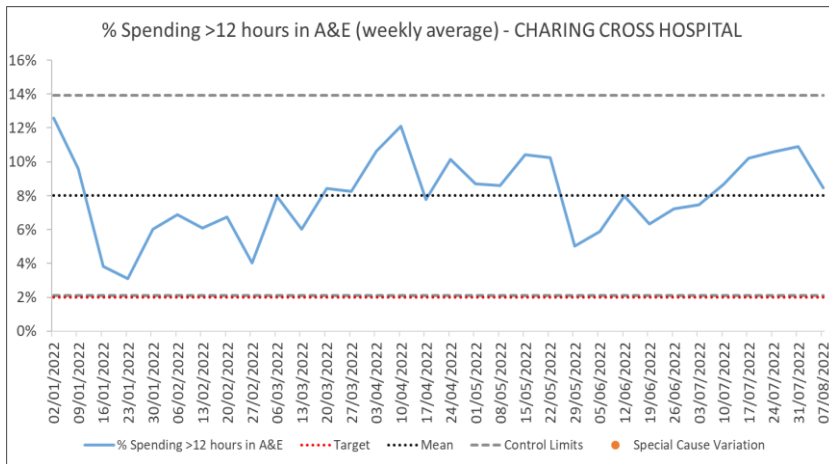


- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

Charing Cross Hospital – ECDS metrics

Source: ECDS

Latest data up to: 07/08/2022

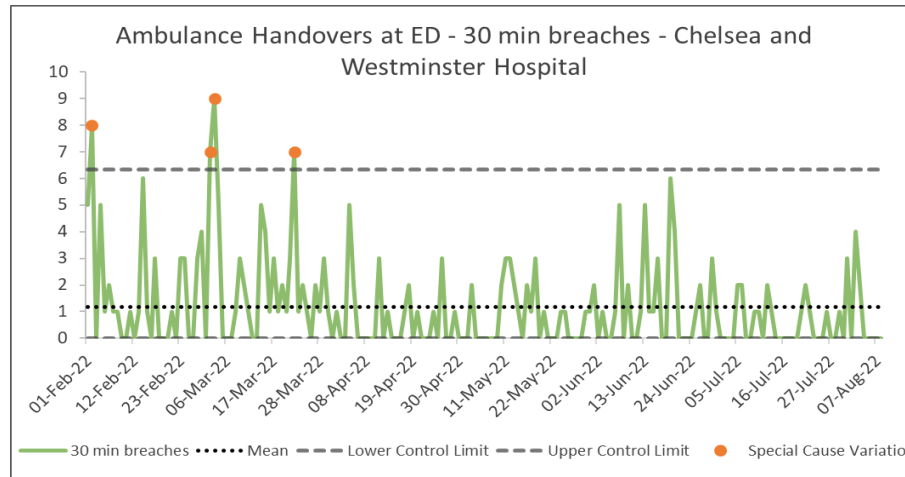
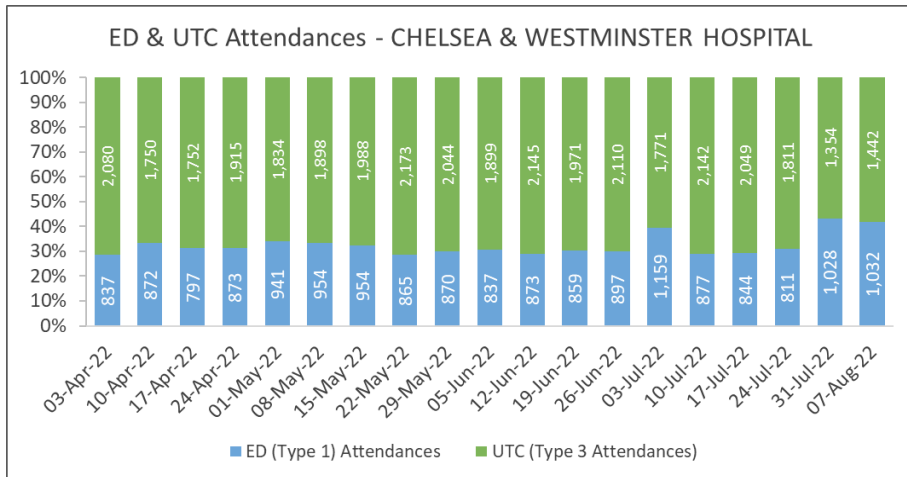
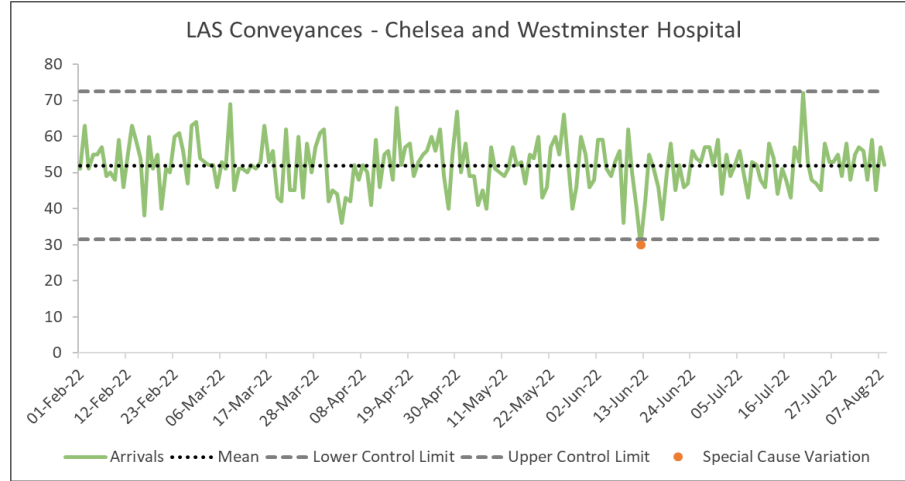
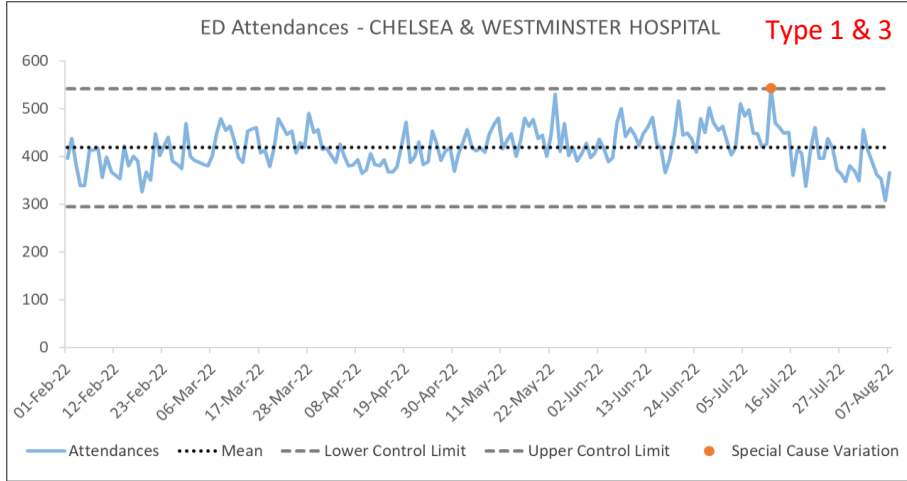


Time spend in ED has climbed sharply since mid March

Chelsea and Westminster – Front Door and LAS

Source: UEC SitRep, LAS Server, ECDS

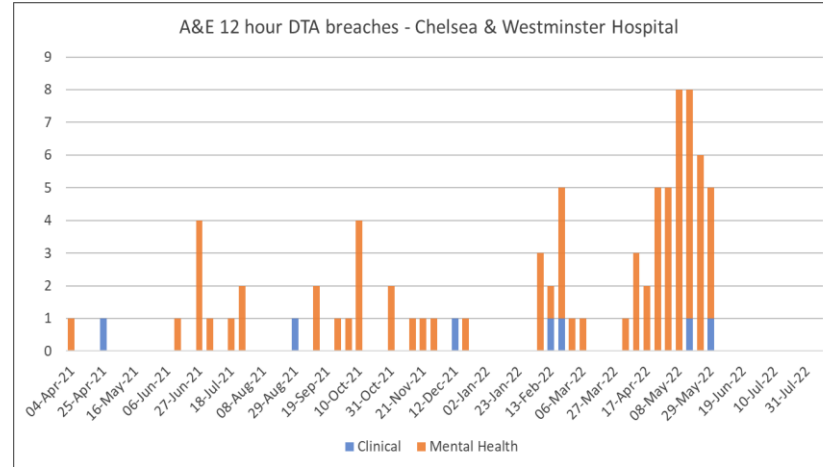
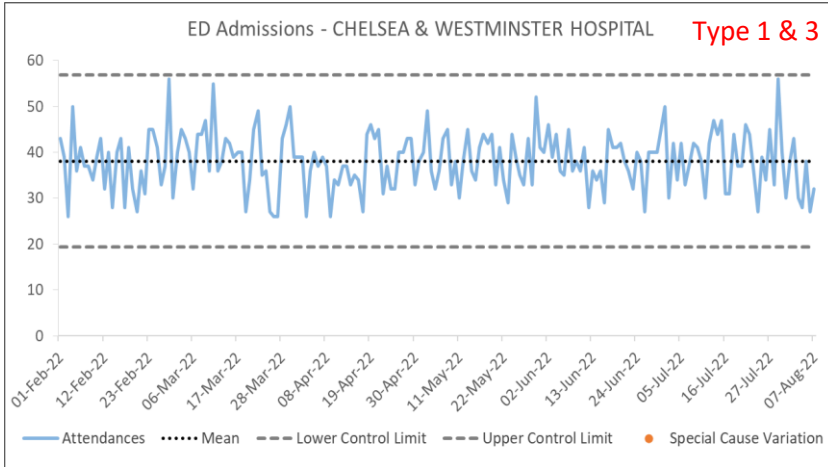
Latest data up to: 07/08/2022



Chelsea and Westminster – Admissions and Discharges

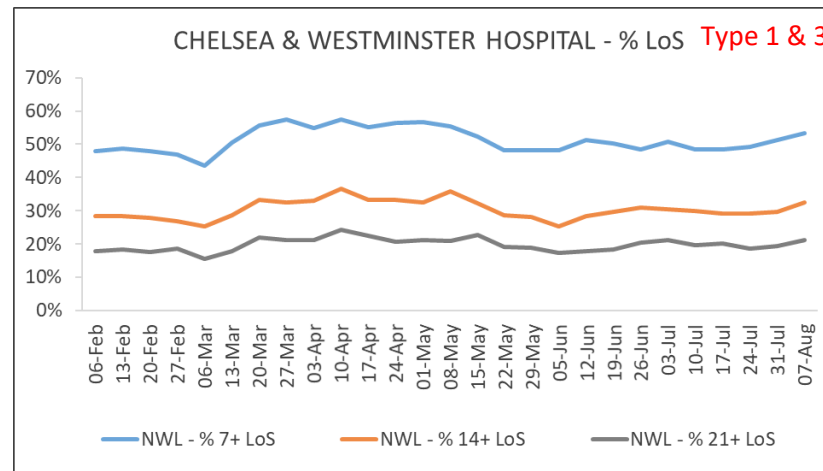
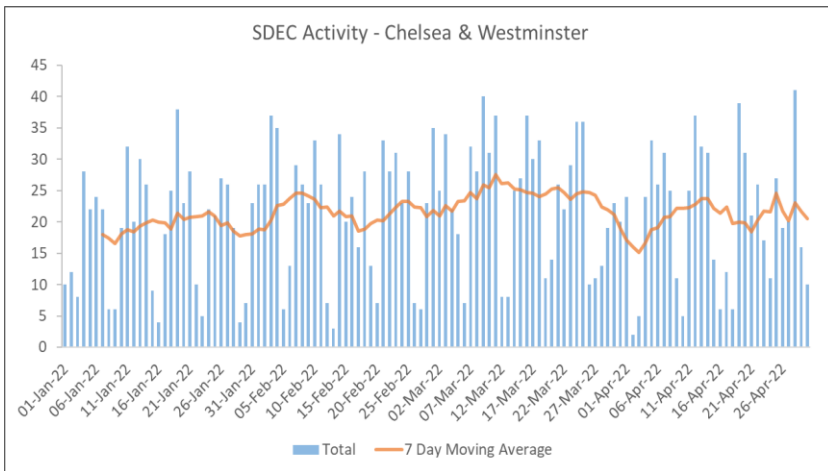
Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022



Rise in LoS since early March

Reported SDEC activity lower than other sites

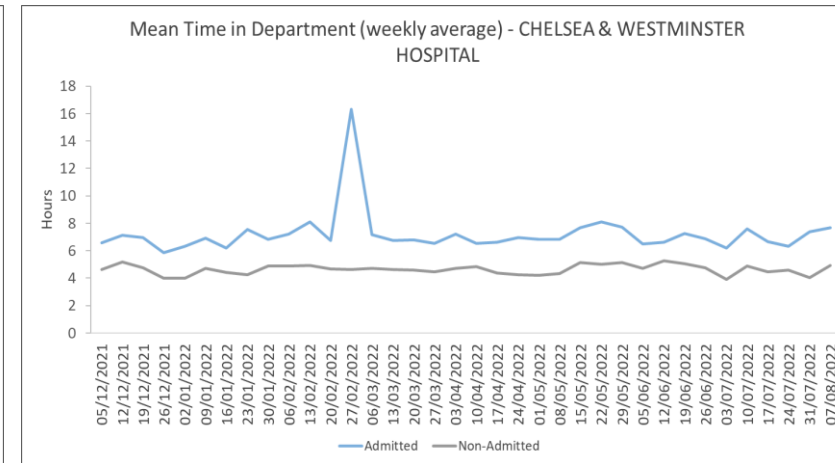
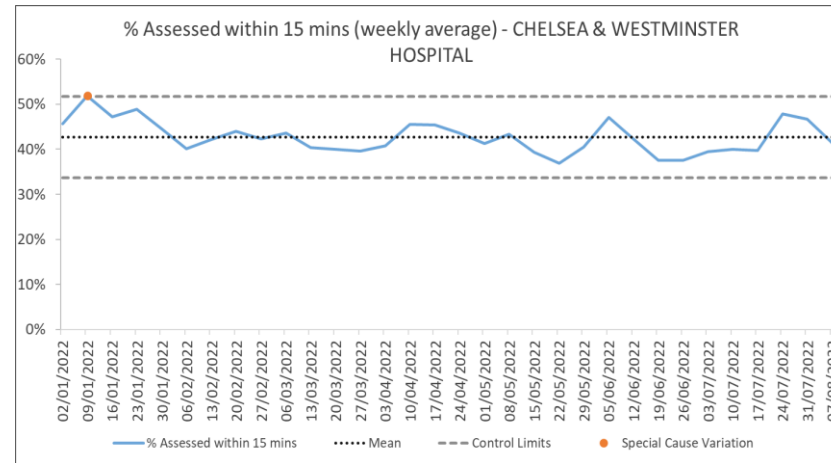
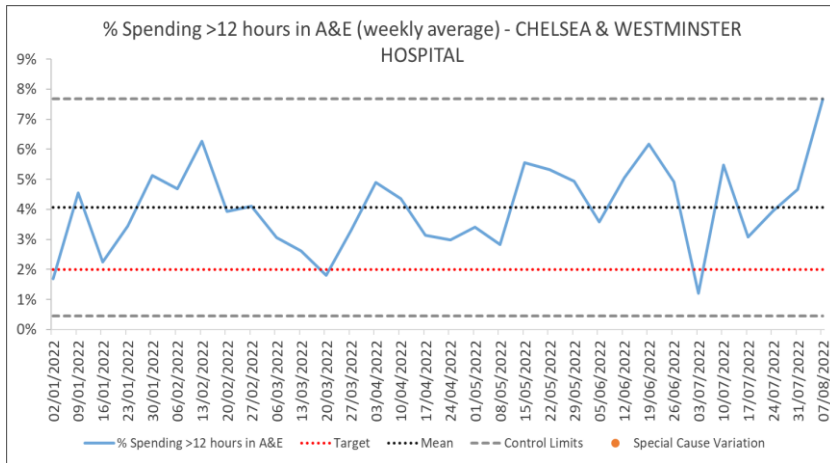


- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

Chelsea & Westminster – ECDS metrics

Source: ECDS

Latest data up to: 07/08/2022

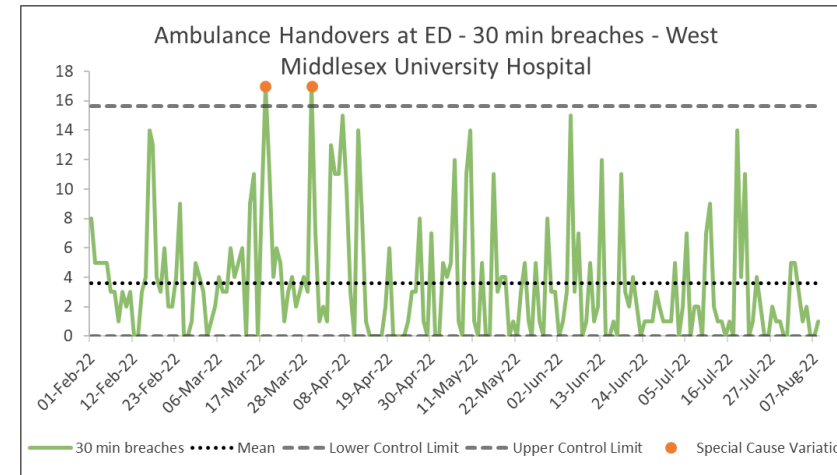
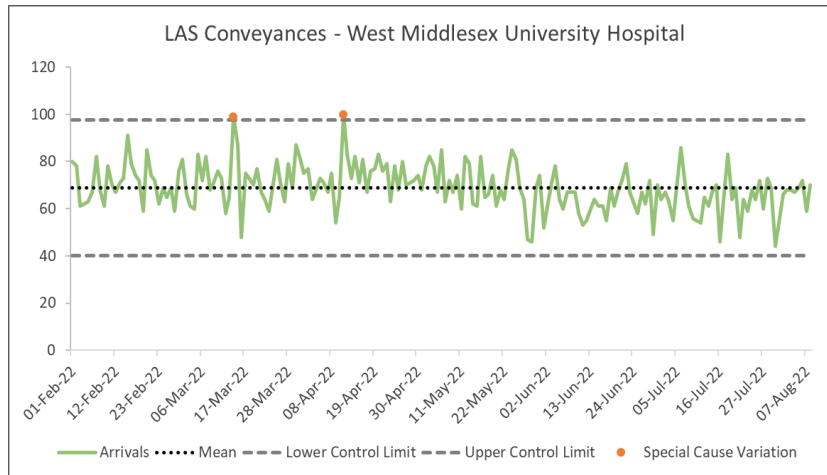
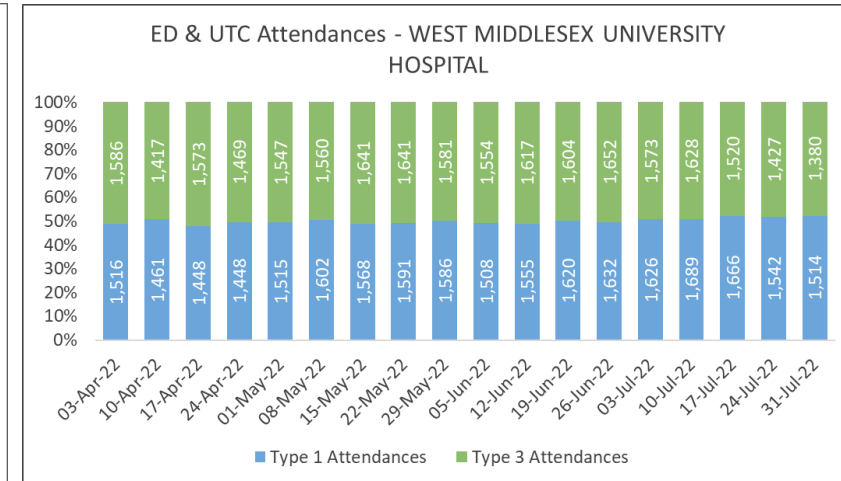
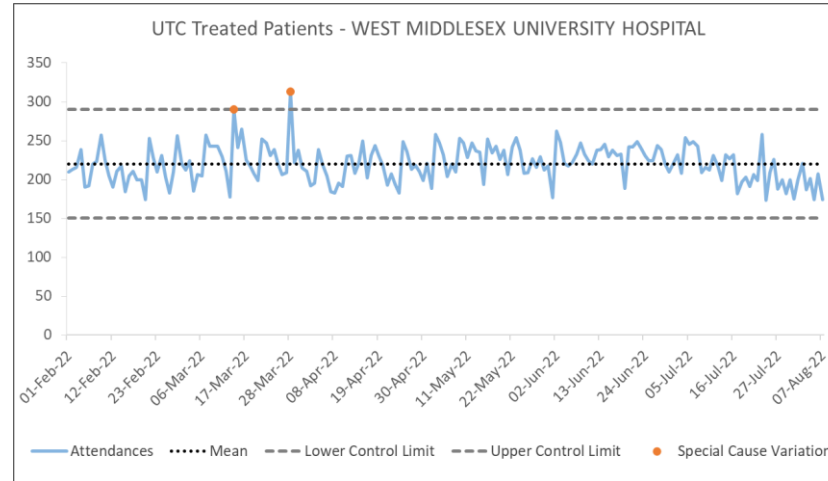
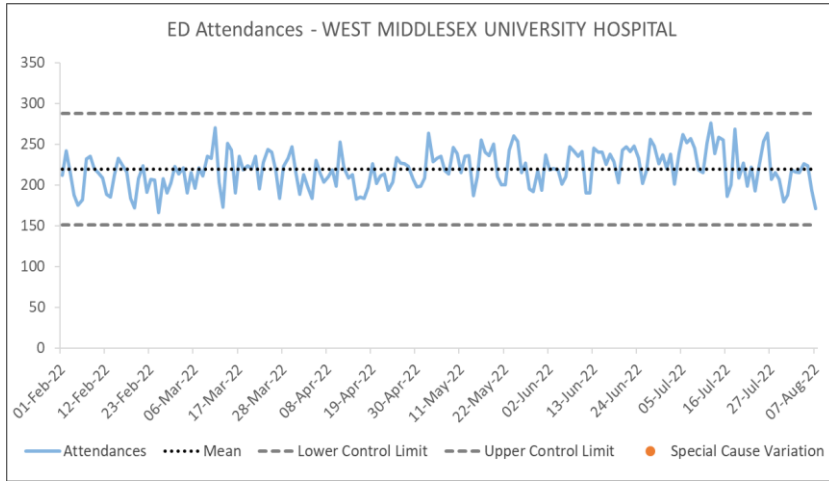


- DQ issue with time spent in ED to be resolved
- Streaming waits improving but below standard

West Middlesex – Front Door and LAS

Source: UEC SitRep, Totally SitRep, LAS Server

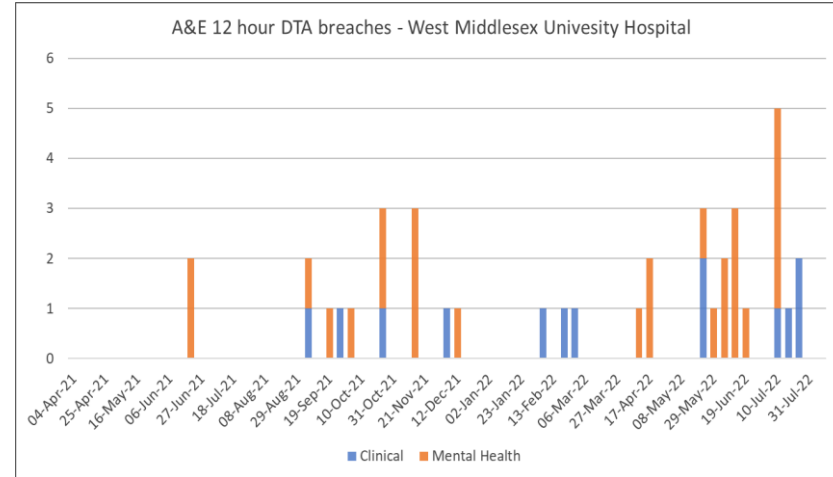
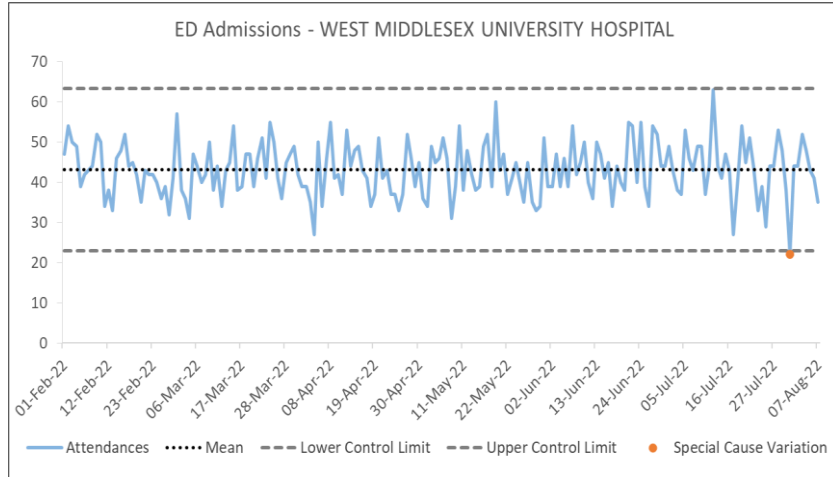
Latest data up to: 07/08/2022



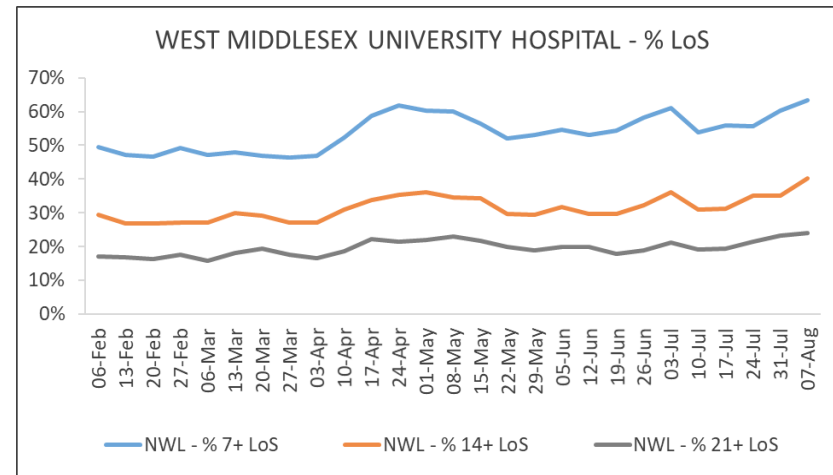
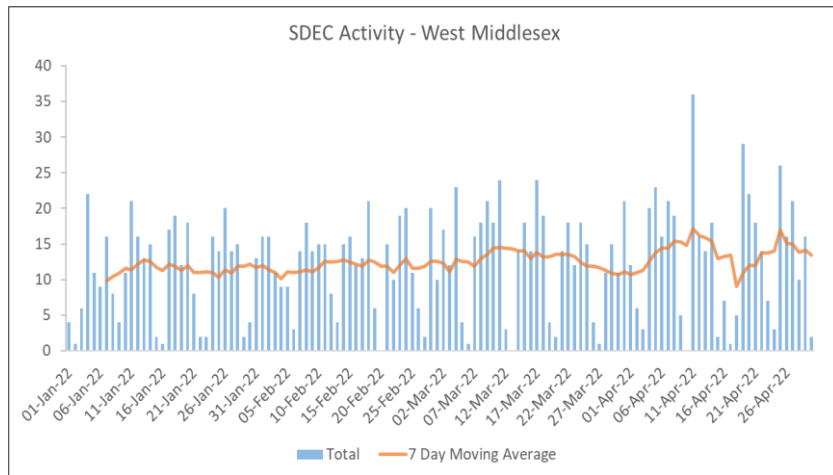
West Middlesex – Admissions and Discharges

Source: UEC SitRep, SUS, Weekly 12hr breaches SitRep

Latest data up to: 07/08/2022



Recent increase in LoS reported

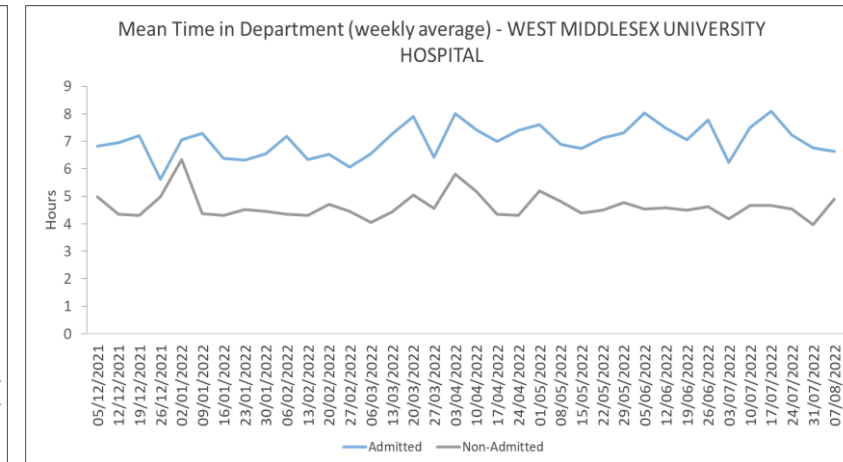
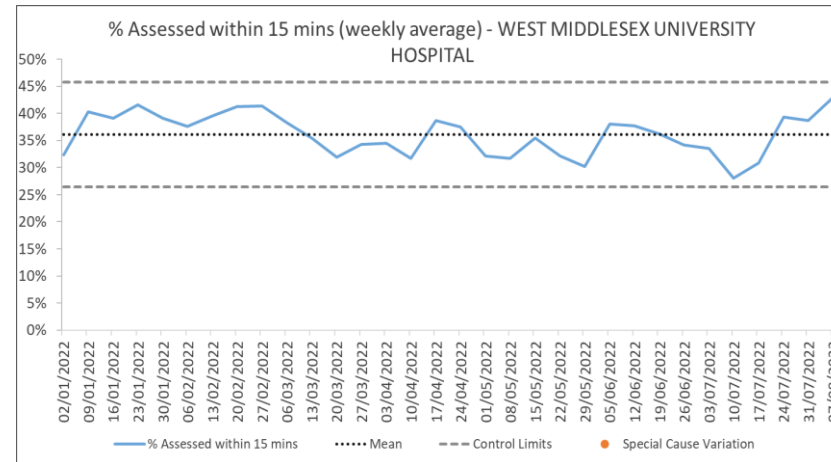
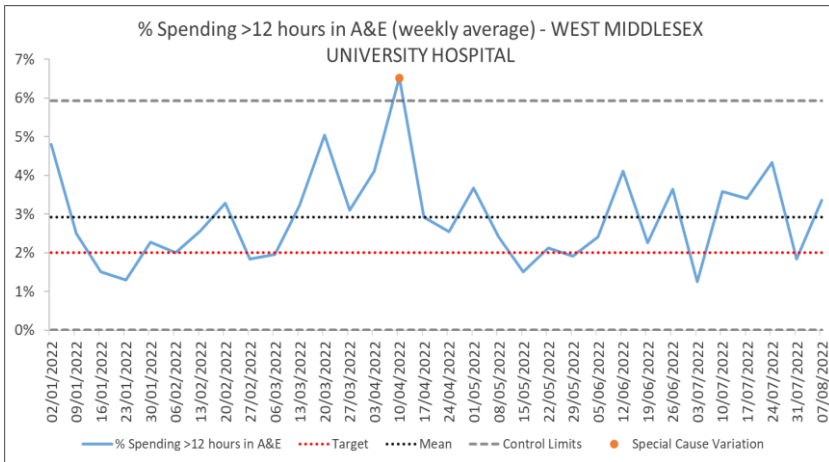


- DQ: SDEC activity reporting paused whilst trusts review their local collection methodology

West Middlesex – ECDS metrics

Source: ECDS

Latest data up to: 07/08/2022

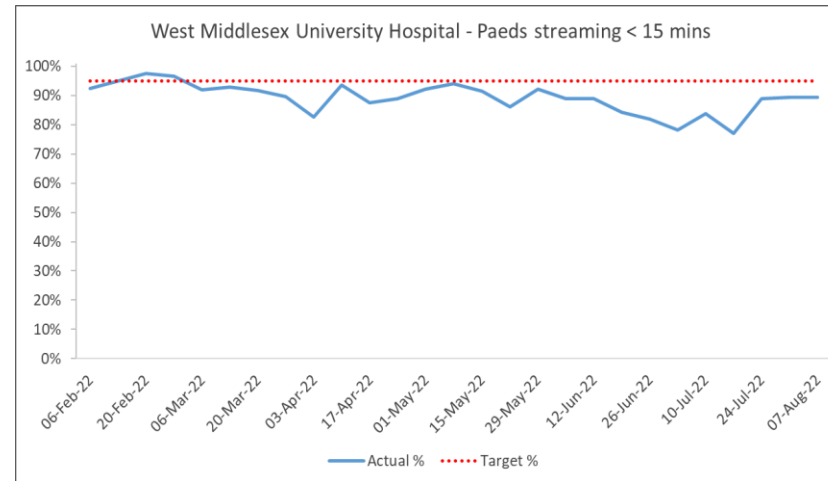
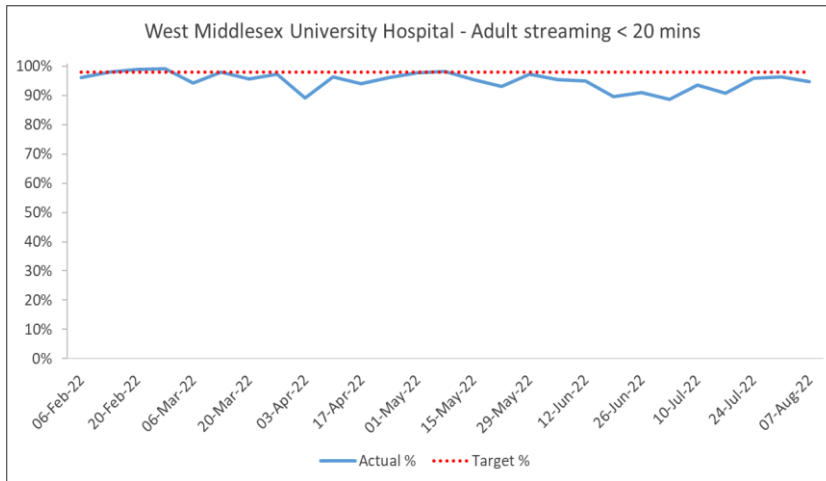
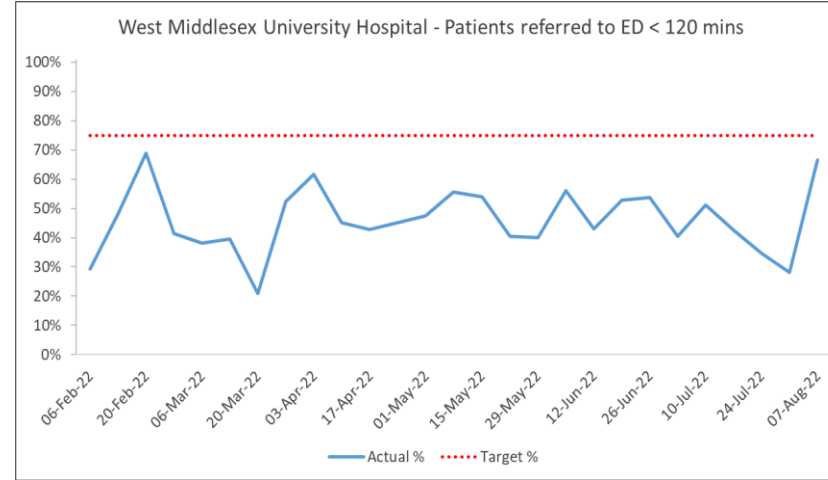
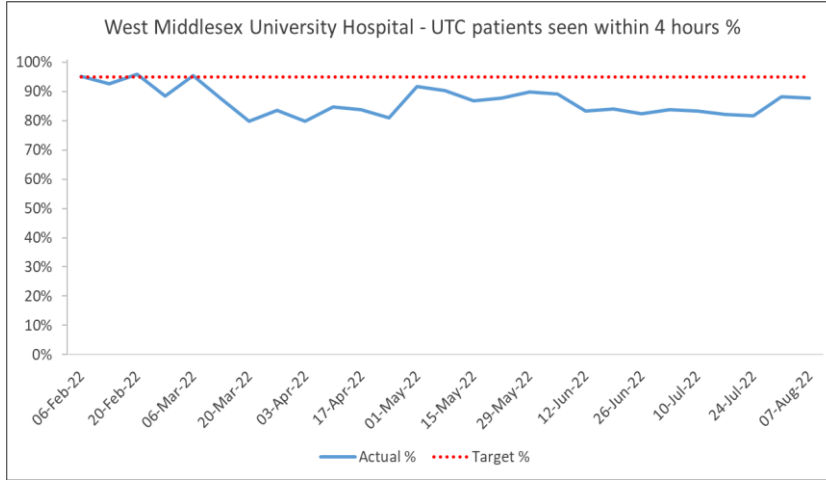


- DQ issue with time spent in ED to be resolved

West Middlesex – UTC

Source: Totally SitRep

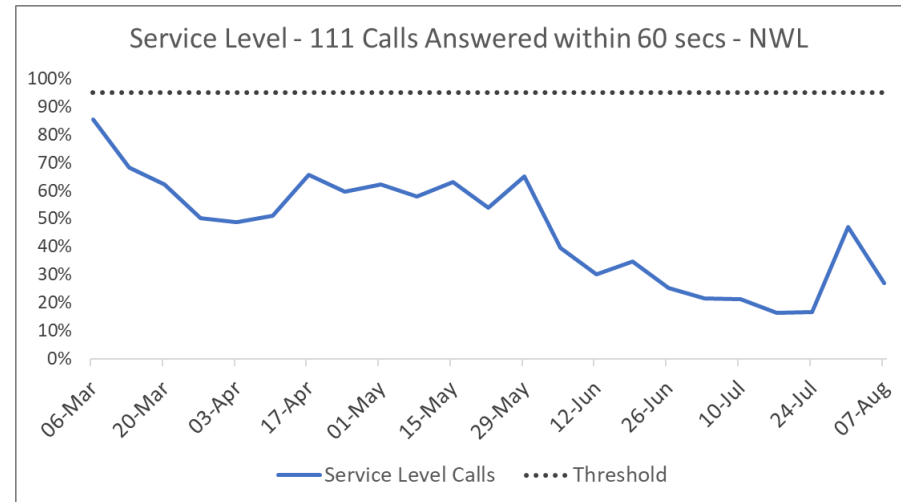
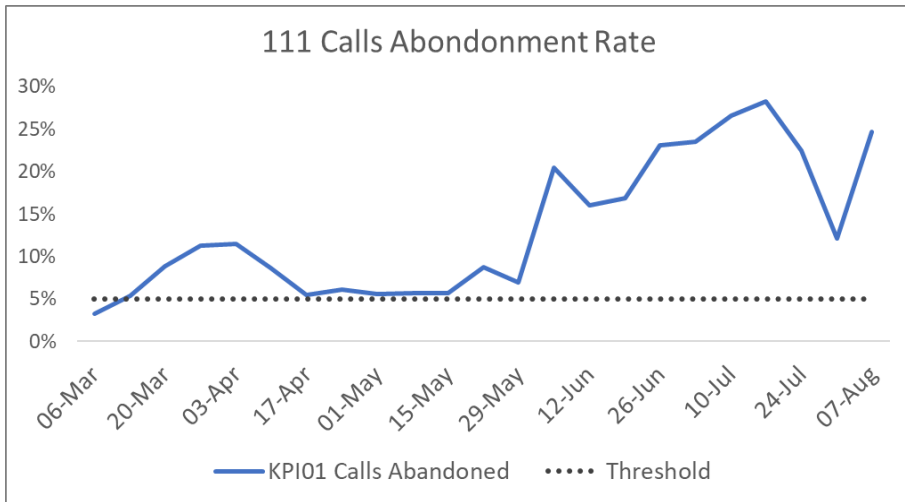
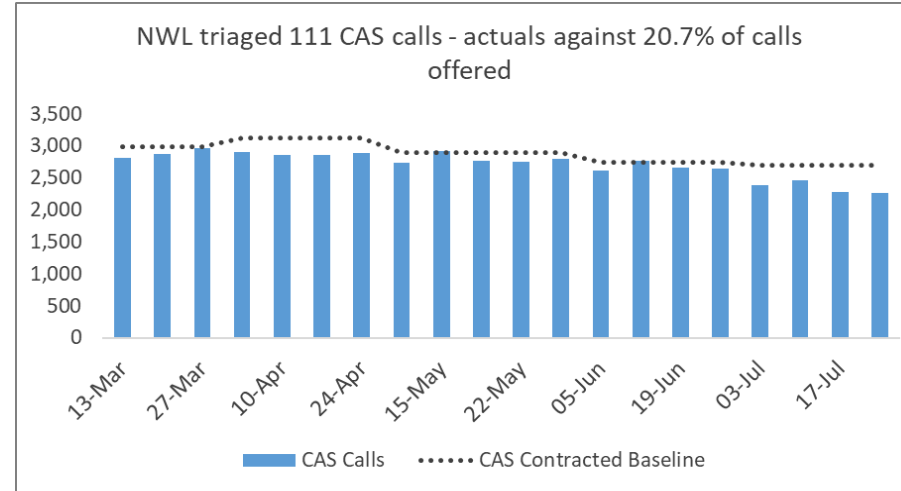
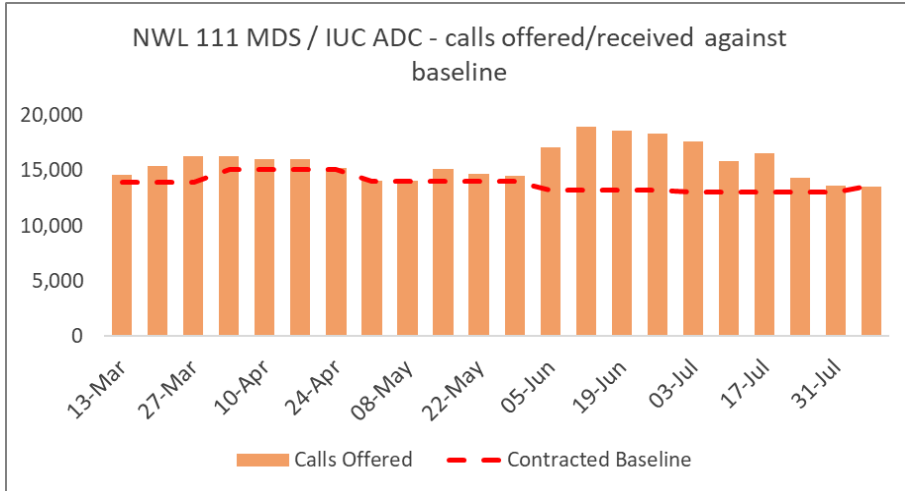
Latest data up to: 07/08/2022



NWL System: 111 indicators

Source: 111_MDS and IUC_ADC (Calls answered and abandoned), [dmic_111] (CAS activity), [performance_CCG].[NHS111].[DirectBooking] - PRM reports (GP in Hours, Ext. Acc. And GP OOH, and UTC bookings), and NWL DoS report (Pharmacy)

Latest data up to: 07/08/2022



Highlights

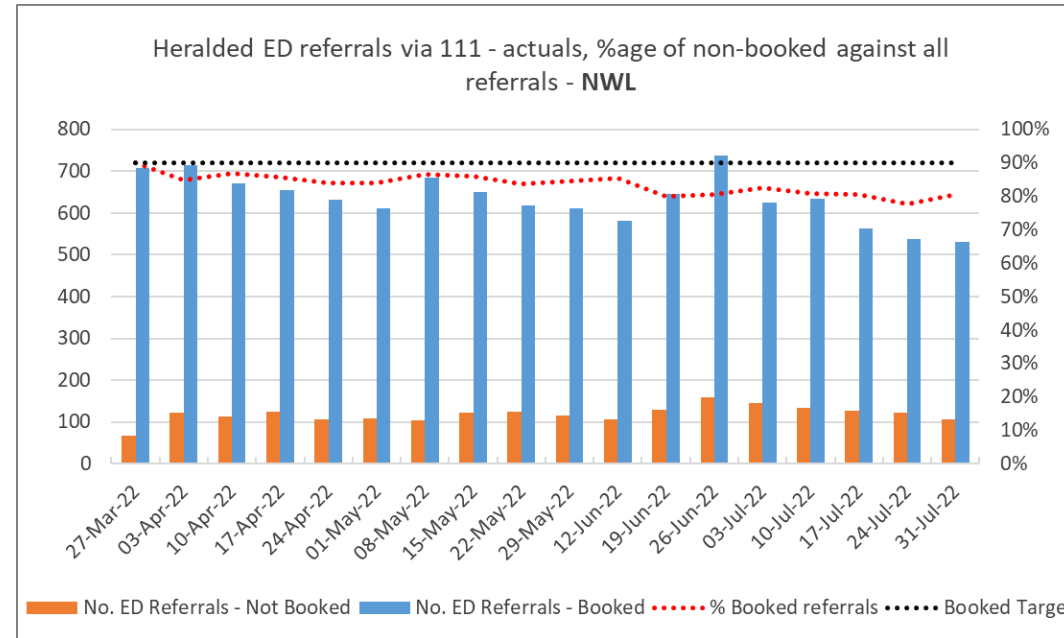
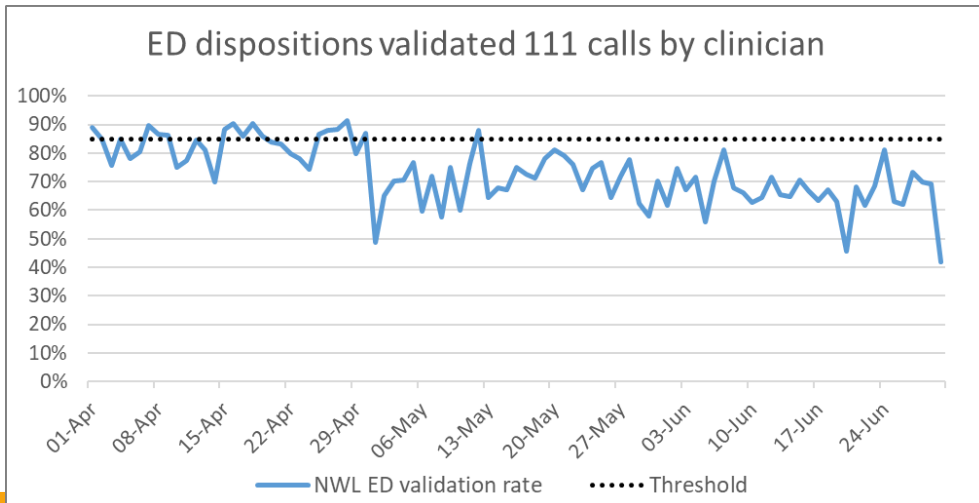
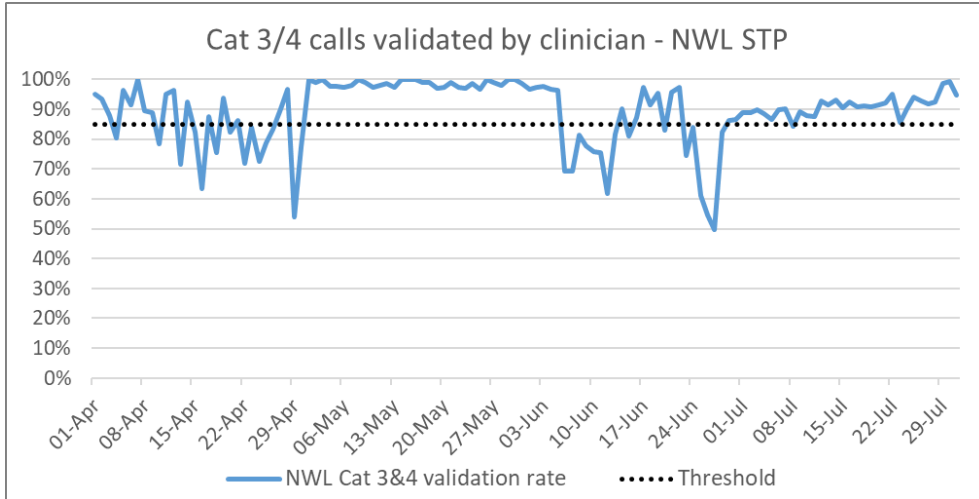
- 111 indicators generally are being met despite an increase in call volumes against the expected contractual baseline
- Calls answered within 60secs is an area of concern and monitored across the NWL providers
- Aadastra system managed by Advanced (used by 111 providers to manage calls) was hit by a cyber security attack on 4th August which will impact the data from this date.

Please note 111 data is currently under review across London due to the introduction of the SVCC in Apr-22. It is not currently validated and discussions are ongoing with NHSE London to agree approach in determining NWL validated numbers.

NWL System: 111 indicators

Source: HLP PRM report

Latest data up to: 07/08/2022



Highlights

- 111 providers continue to be monitored against the ED validation target of 85%.
- 111 online patients pathway for ED continues to be reviewed by Regional Clinicians with a view to moving these into the CAS in the first instance.
- **Adastra system managed by Advanced (used by 111 providers to manage calls) was hit by a cyber security attack on 4th August which will impact the data from this date.**

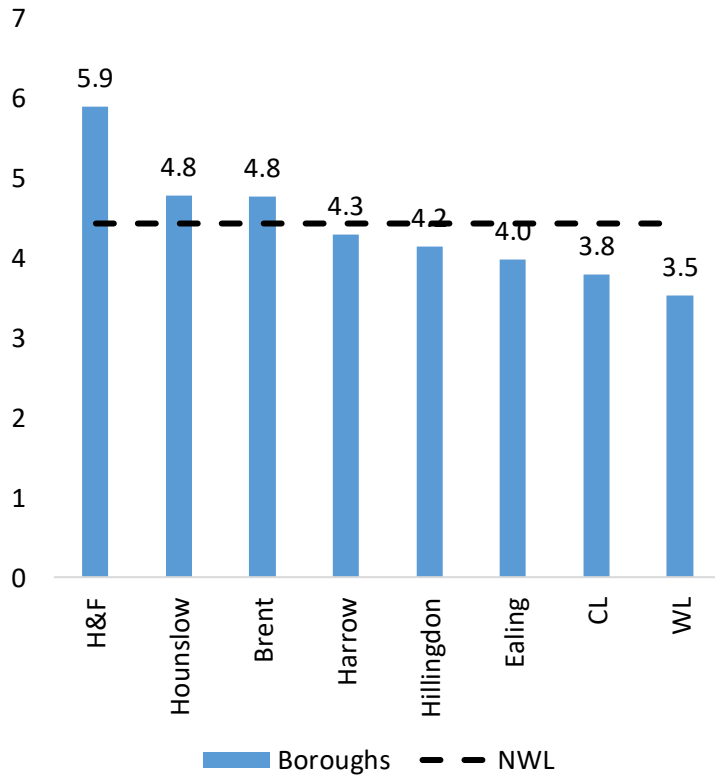
Please note 111 data is currently under review across London due to the introduction of the SVCC in Apr-22. It is not currently validated and discussions are ongoing with NHSE London to agree approach in determining NWL validated numbers.

NWL System: GP Appointments Booked via 111 Summary

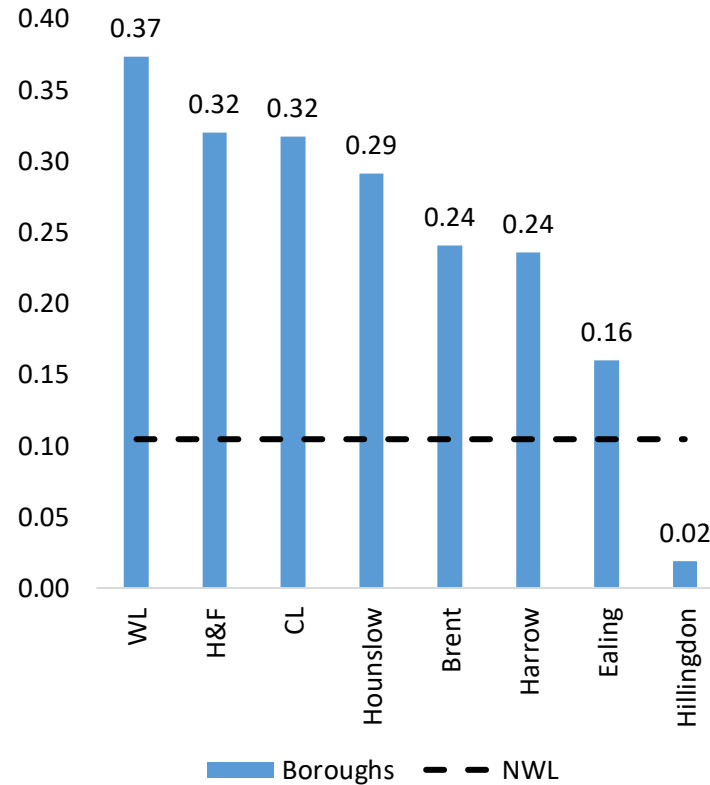
Source: NHS Digital Direct Care APIs Report

Latest data up to: 25/07/2022

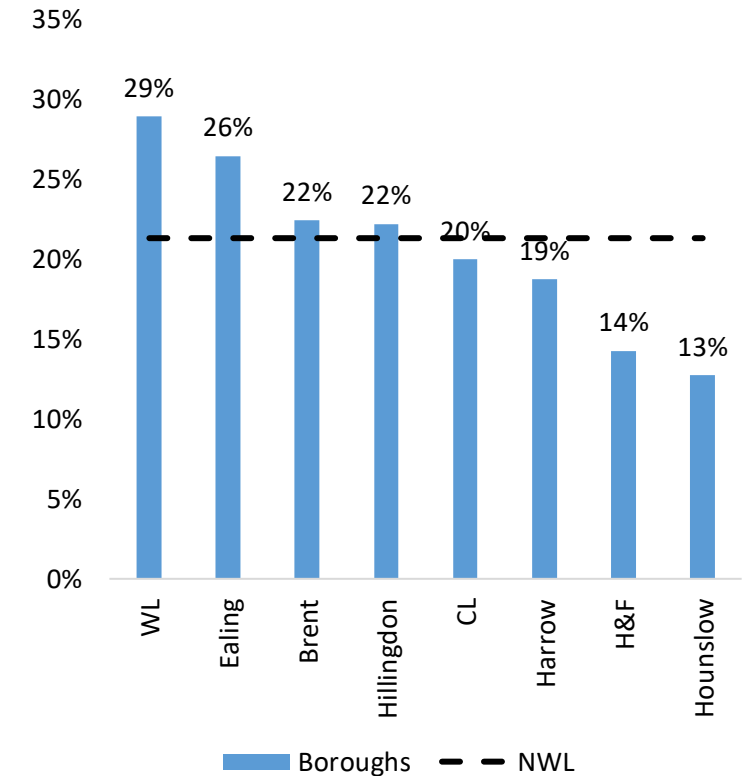
GP Appointments Booked via 111 per 10,000 List Size 25/07/22



Number of Bookings per Search via 111 in previous week 25/07/22



% of Practices with a Booking via 111 CCG_Bookings 25/07/22



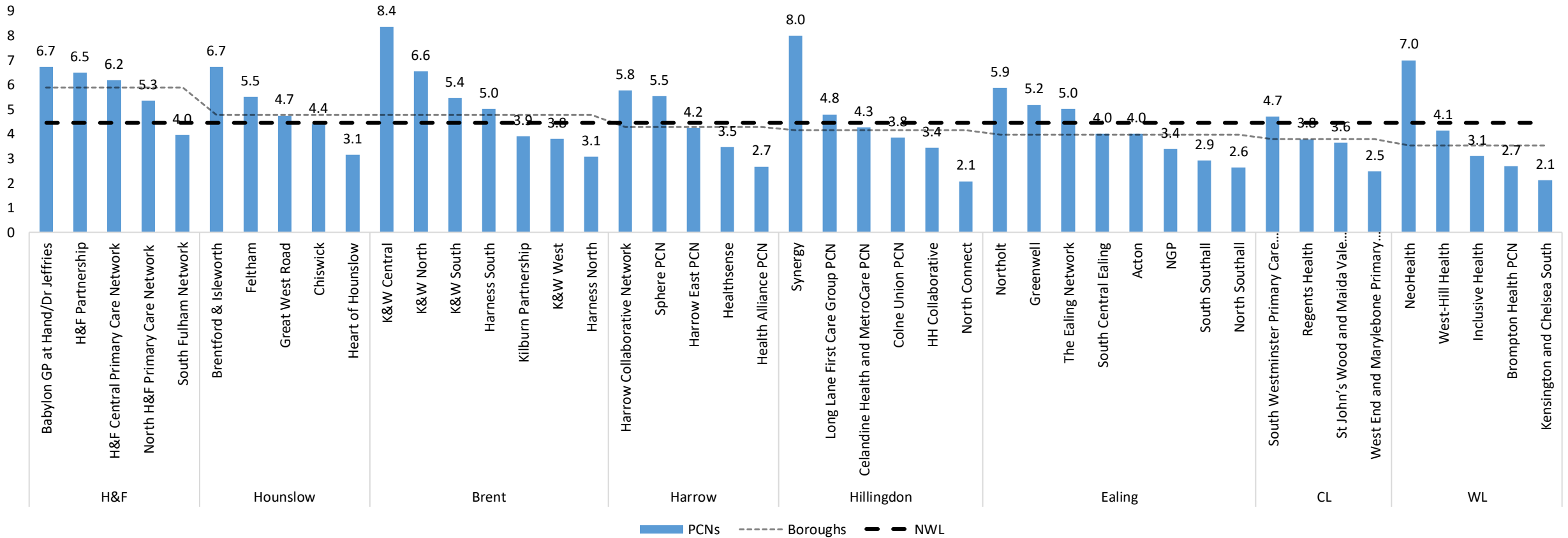
Please note Hillingdon figures in middle graph from 'Number of Bookings per Search' graph have suspected data quality issues.

NWL System: Appointments Booked via 111 per 10,000 List Size

Source: NHS Digital Direct Care APIs Report

Latest data up to: 25/07/2022

GP Appointments Booked via 111 per 10,000 List Size 25/07/22

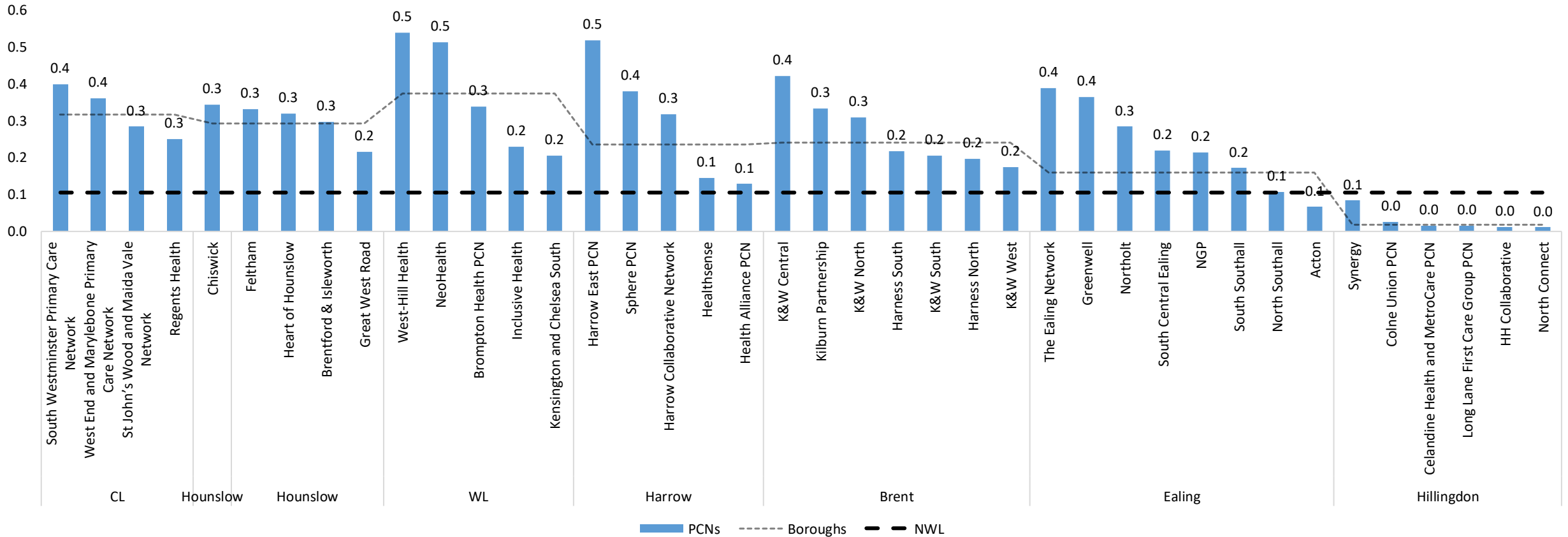


NWL System: Number of Bookings per Search via 111

Source: NHS Digital Direct Care APIs Report

Latest data up to: 25/07/2022

Number of Bookings per Search via 111 in previous week
25/07/22



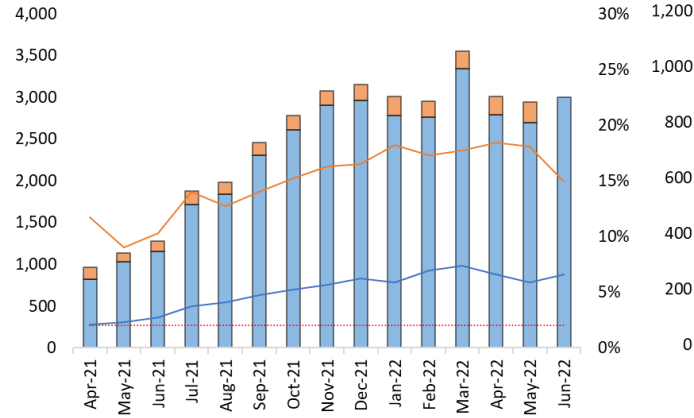
Please note Hillingdon figures have suspected data quality issues.

NWL System: Patients spending >12 hours in A&E

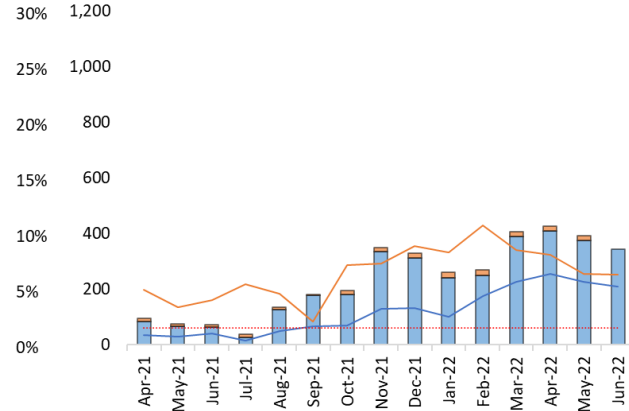
Source: SUS and Liaison Psychiatry Referrals dataset

Latest data up to: 30/06/2022

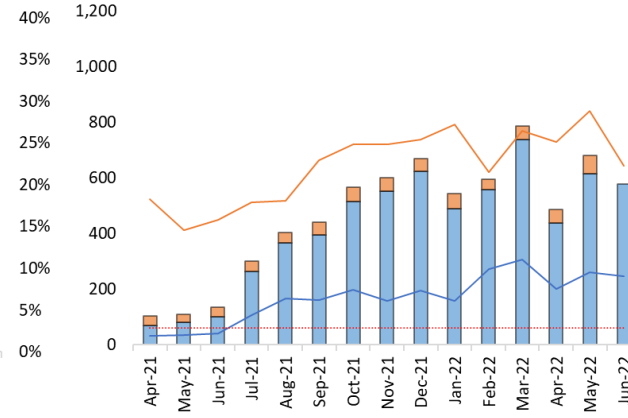
NWL



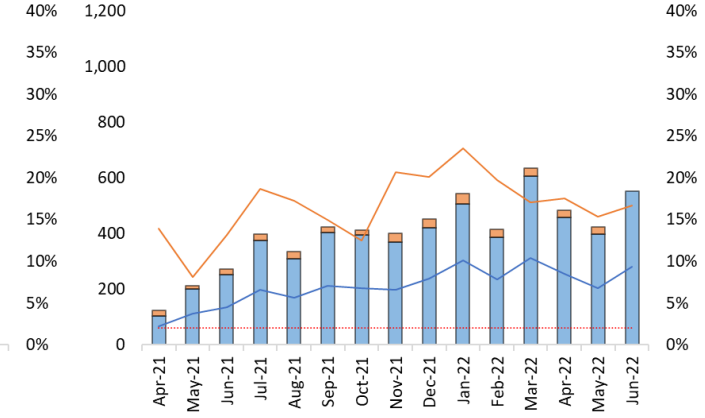
CHARING CROSS HOSPITAL



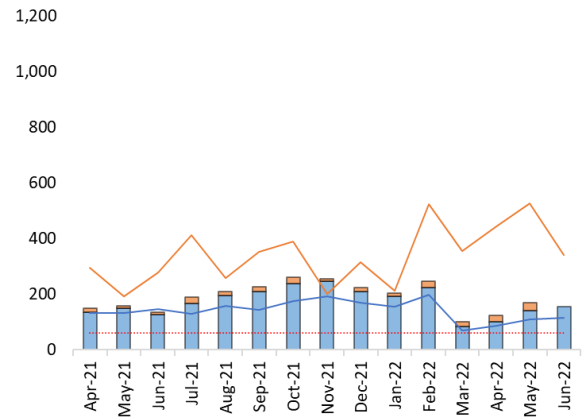
ST MARYS HOSPITAL



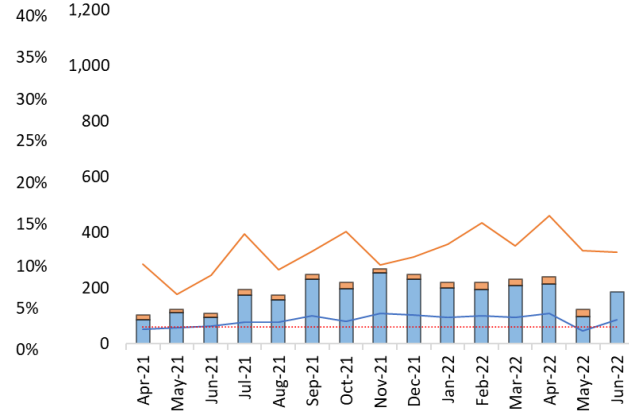
HILLINGDON HOSPITAL



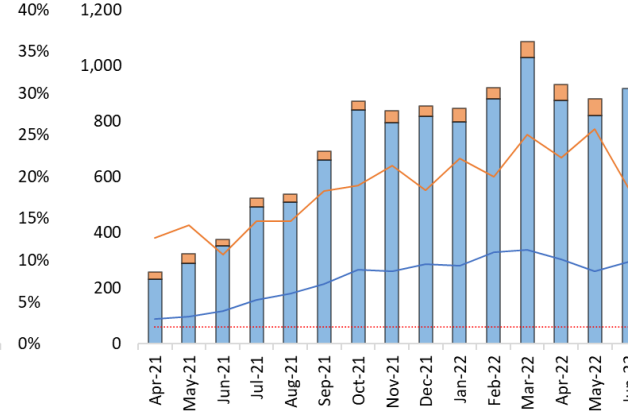
CHELSEA & WESTMINSTER HOSPITAL



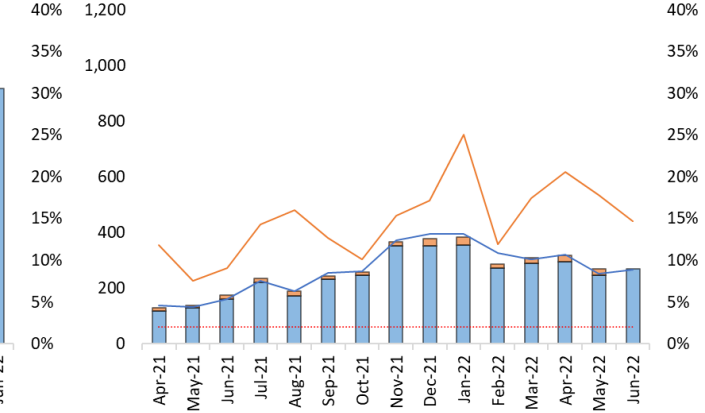
WEST MIDDLESEX UNIVERSITY HOSPITAL



NORTHWICK PARK HOSPITAL



EALING HOSPITAL



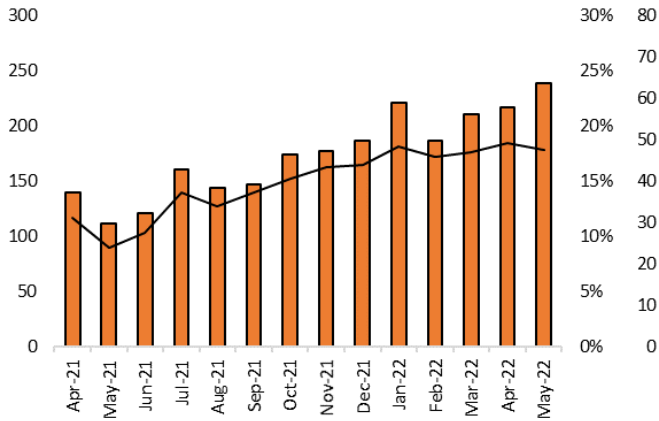
Physical Health 12hr # Mental Health 12hr # Physical Health 12hr % Mental Health 12hr % 12hrs % Threshold (2%)

NWL System: Mental Health Patients spending >12 hours in A&E

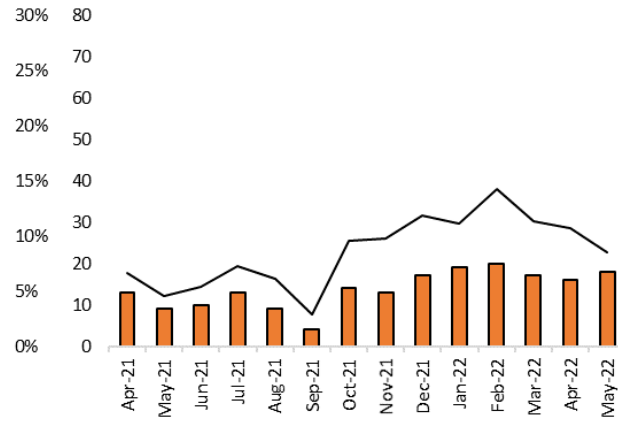
Source: SUS and Liaison Psychiatry Referrals dataset

Latest data up to: 31/05/2022 – Awaiting data for June 2022

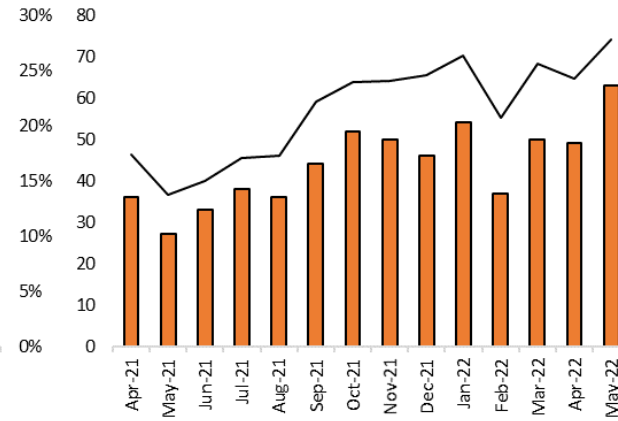
NWL



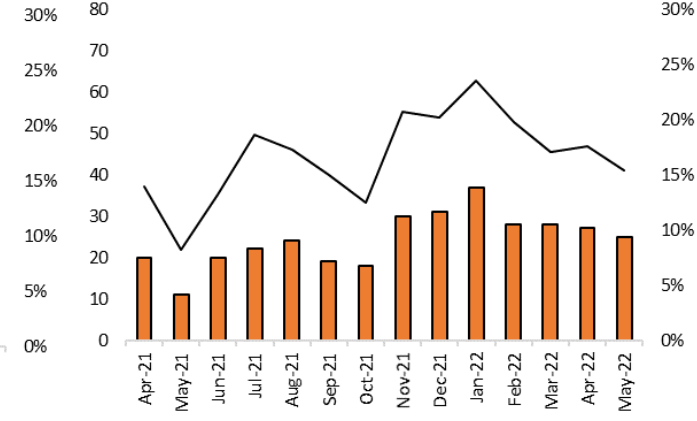
CHARING CROSS HOSPITAL



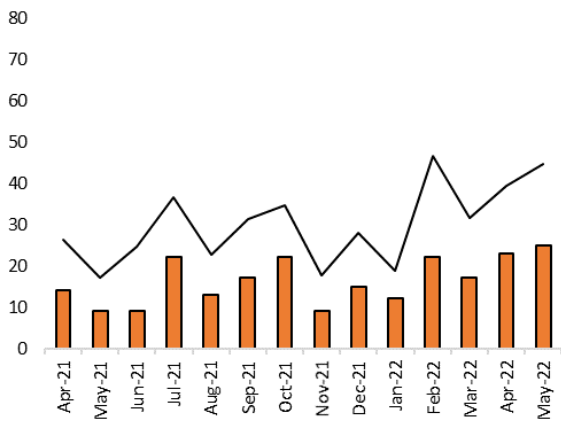
ST MARYS HOSPITAL



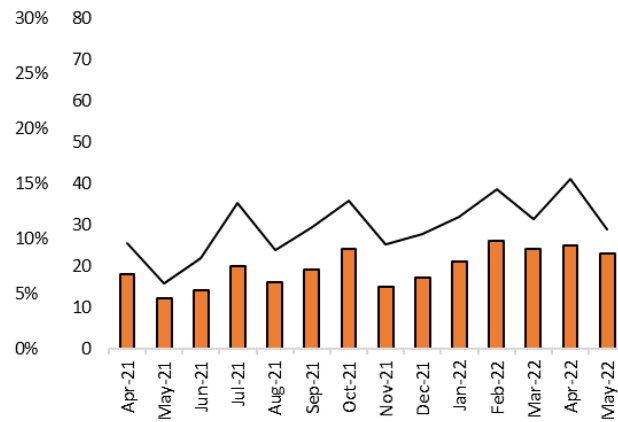
HILLINGDON HOSPITAL



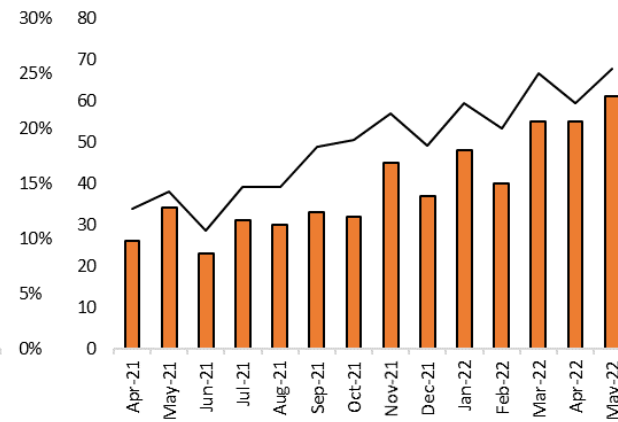
CHELSEA & WESTMINSTER HOSPITAL



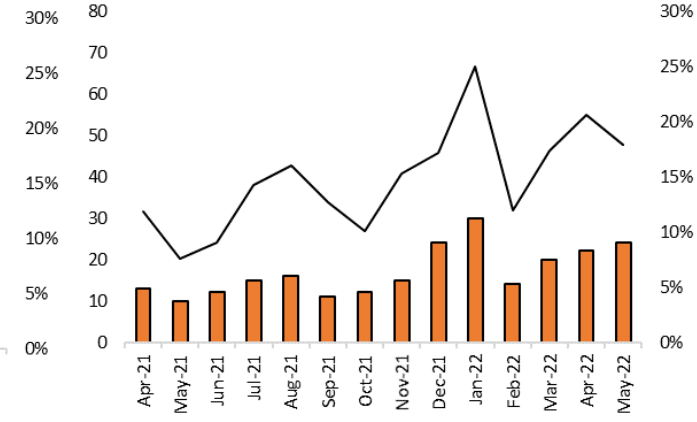
WEST MIDDLESEX UNIVERSITY HOSPITAL



NORTHWICK PARK HOSPITAL



EALING HOSPITAL



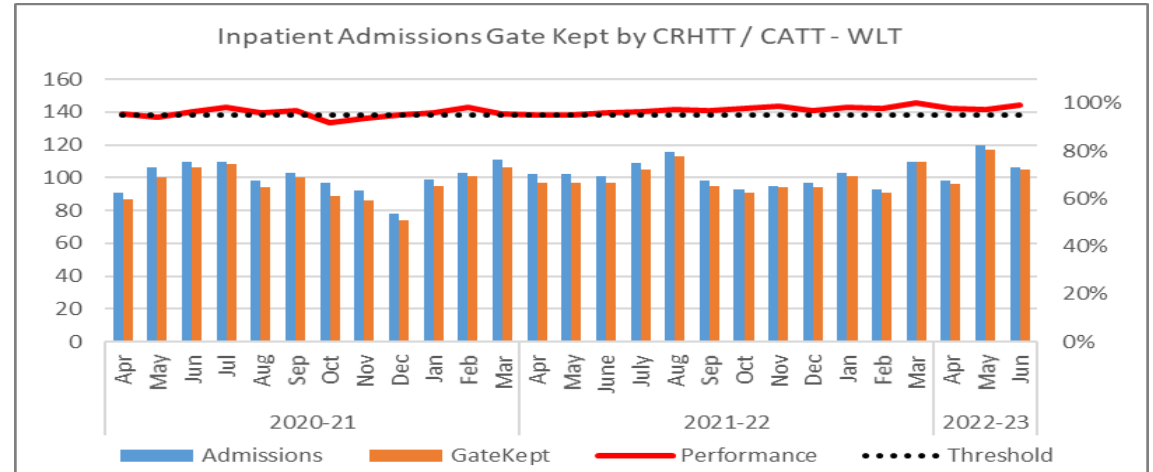
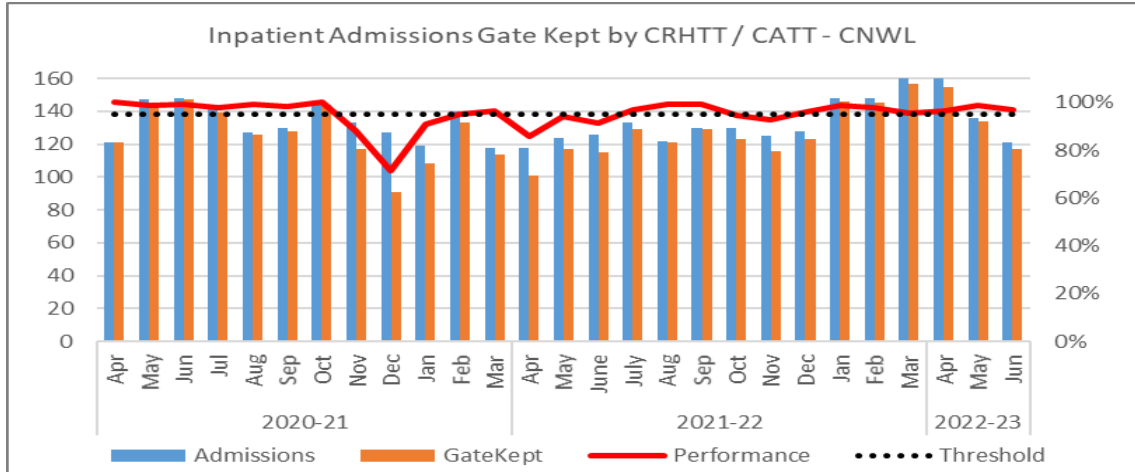
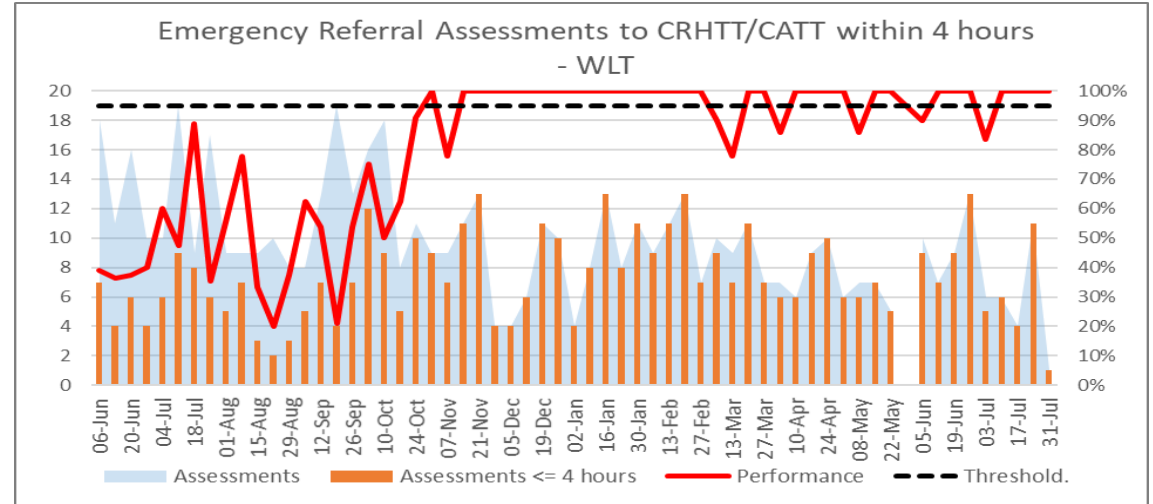
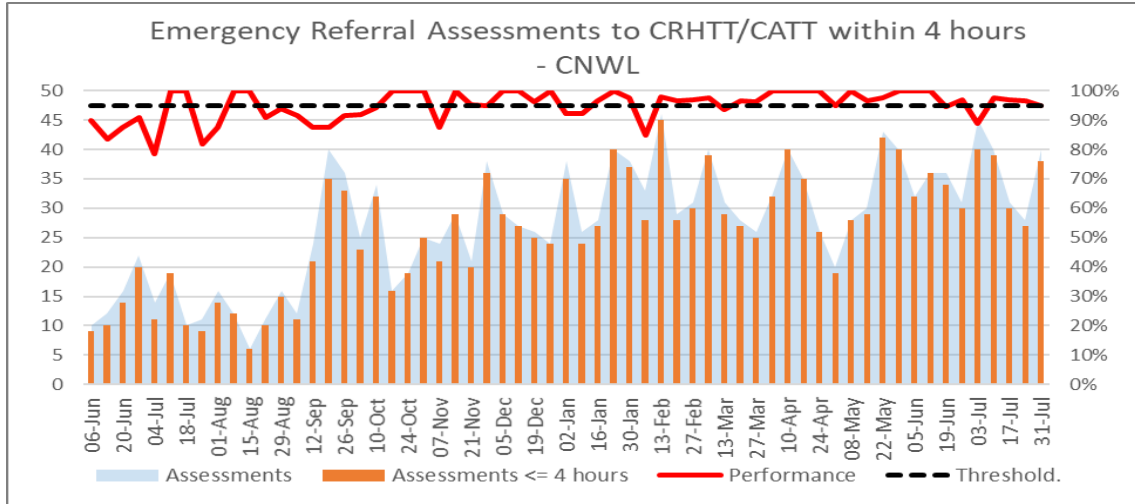
 Mental Health 12hr #

 Mental Health 12hr %

NWL System: Mental Health indicators

Source: Emergency Referral Assessments to community crisis teams charts:- Weekly Crisis SITREPS
 Inpatient Admissions Gate Kept charts:- Monthly Provider MIR

Latest data up to: 31/07/2022

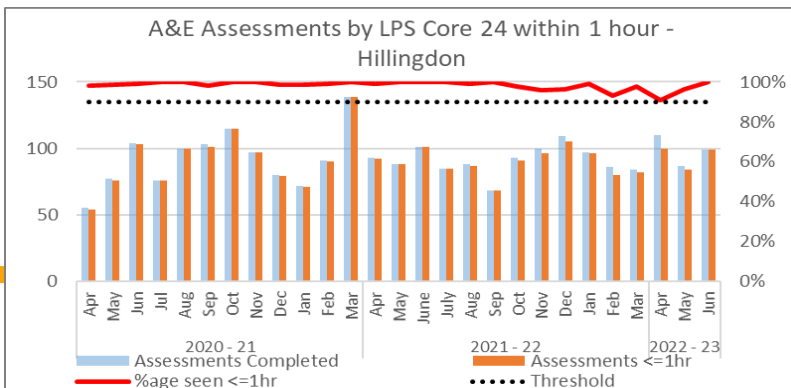
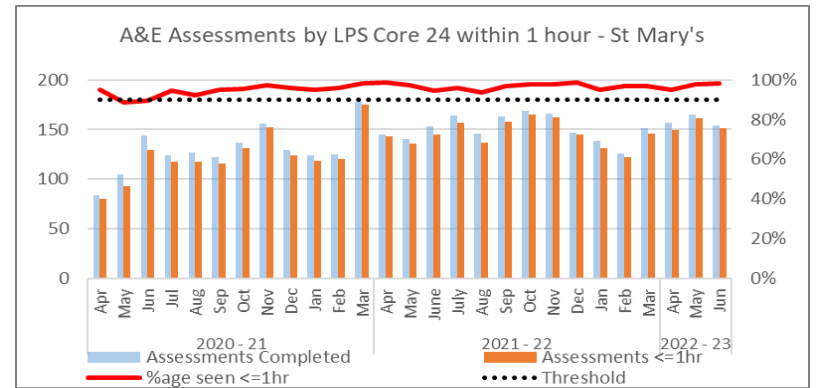
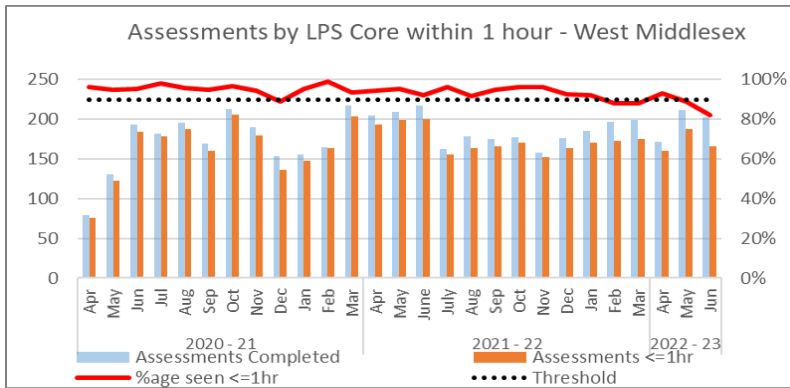
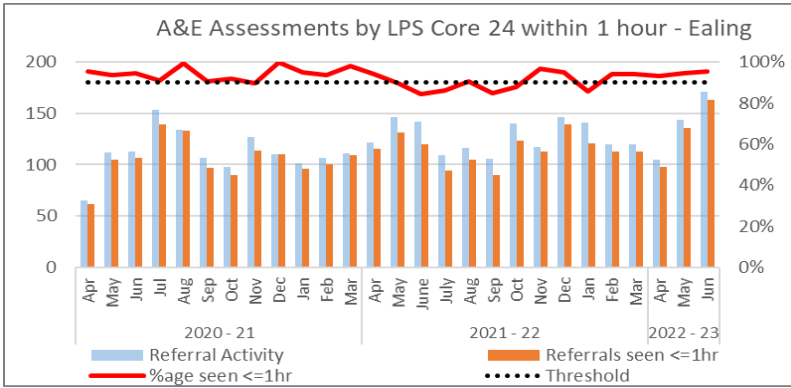
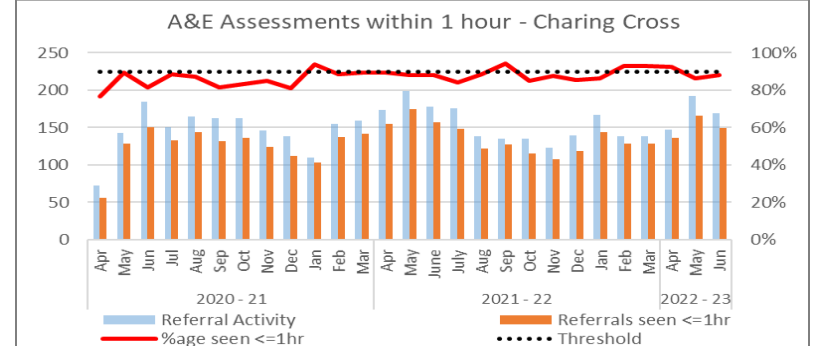
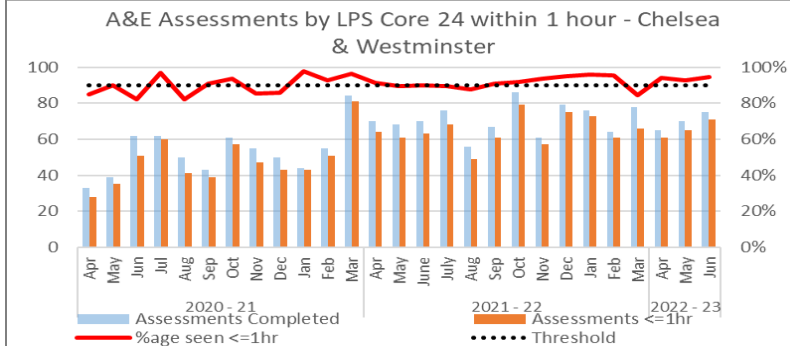
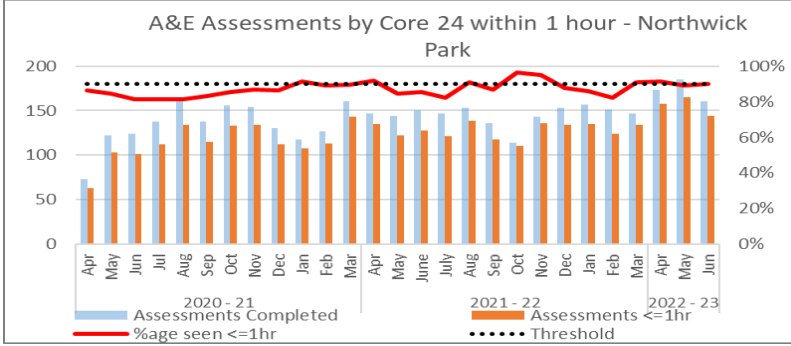


NWL System: Mental Health indicators

Source: CNWL sites – Monthly Performance MIR return submitted by Provider. WLT – Monthly LPS patient level data set to June 2021 and Monthly Performance MIR from July 2021

Note: Whereas WLT includes all patients, CNWL only includes NWL registered patients
No of assessments to Core 24 Liaison Psychiatry Teams and % within 1 hr

Data to: Jun-22

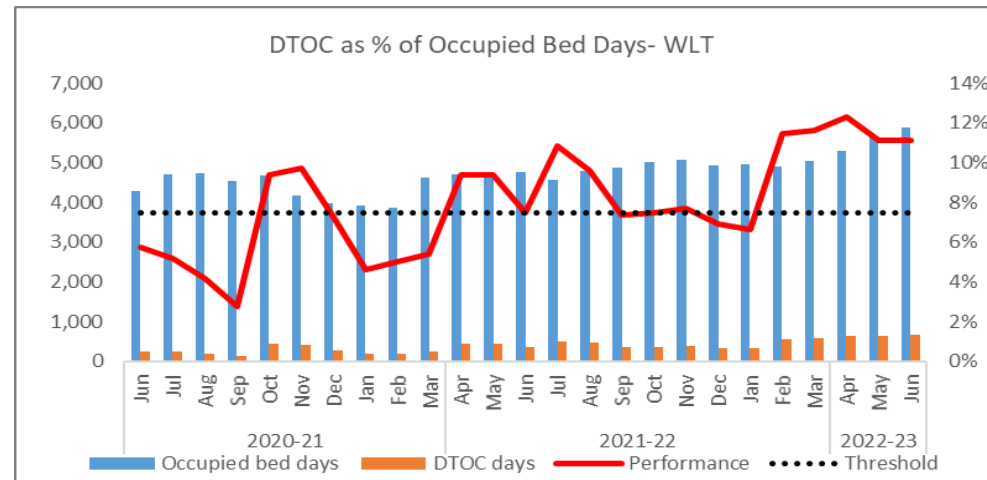
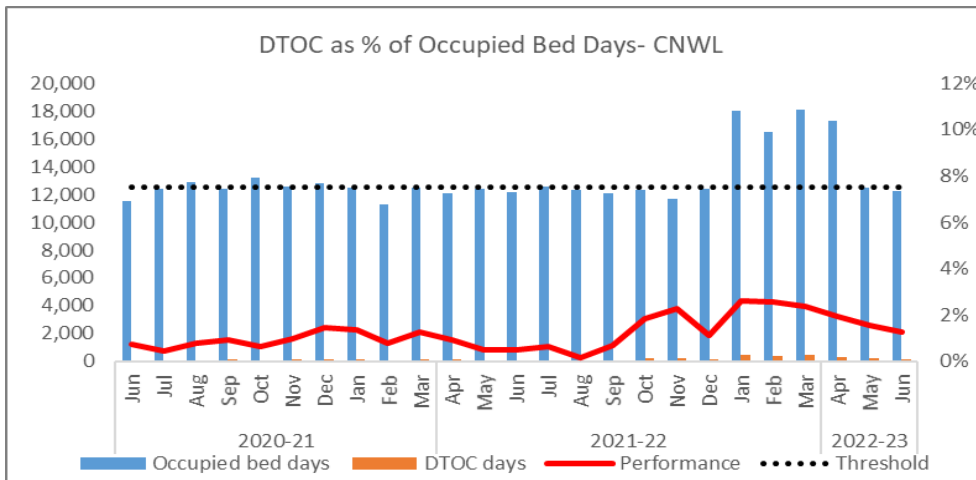
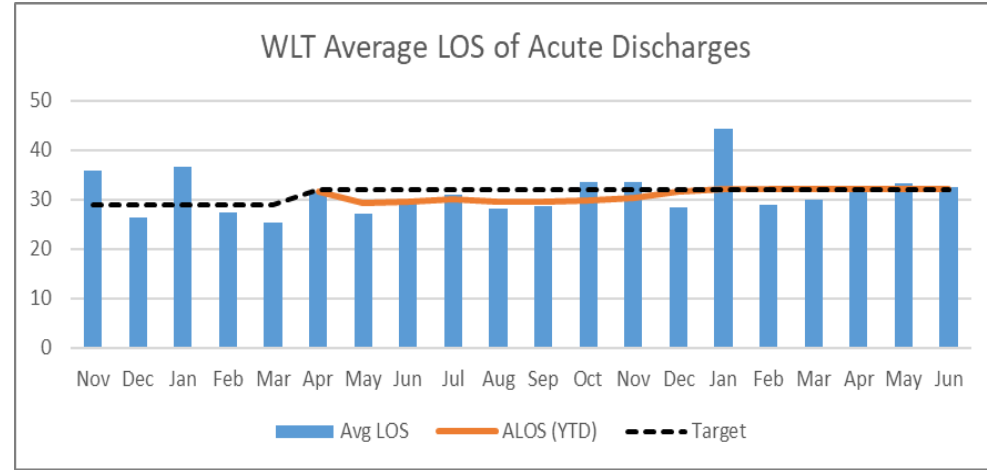
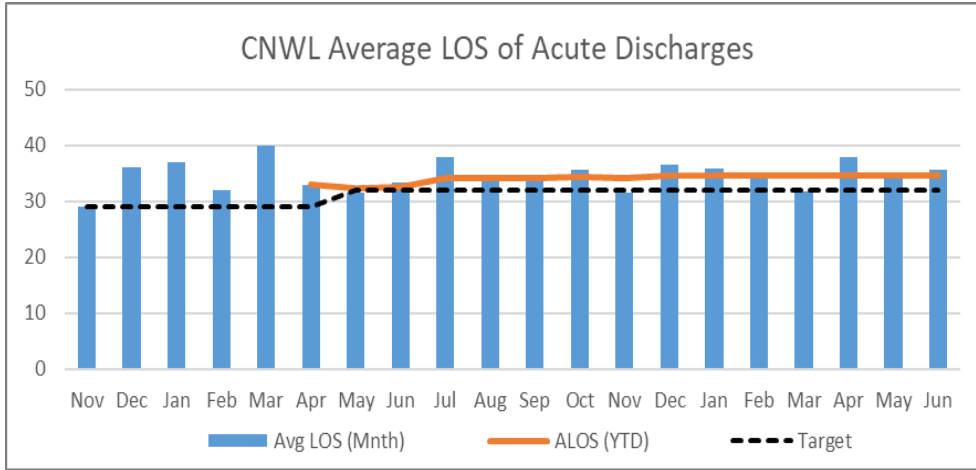


Most sites close to or at standard though reduction in performance at C&W and West Mid over the last three months

NWL System: Mental Health Average Length of Stay and DTOC

Source: Monthly Provider MIR

Data to: Jun-22

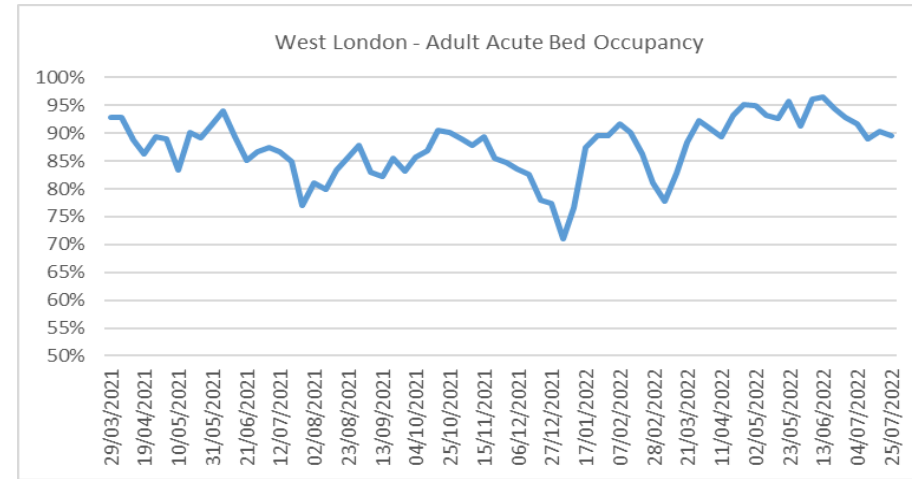
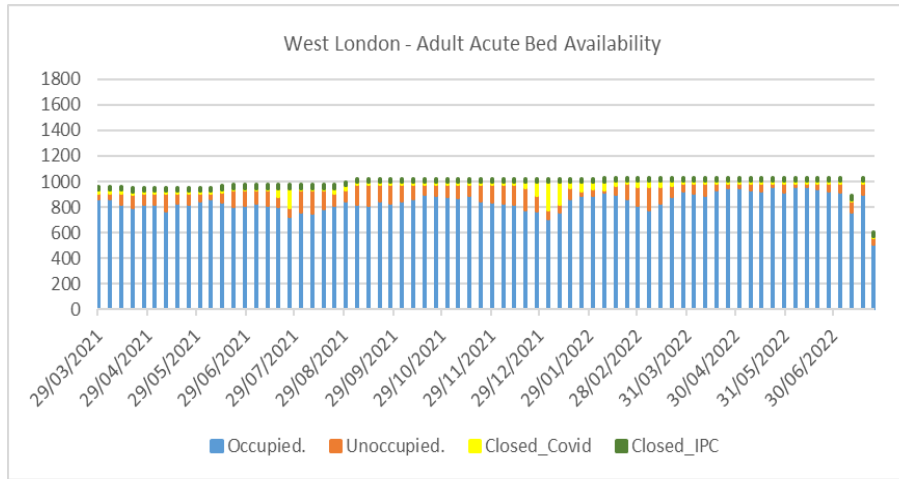
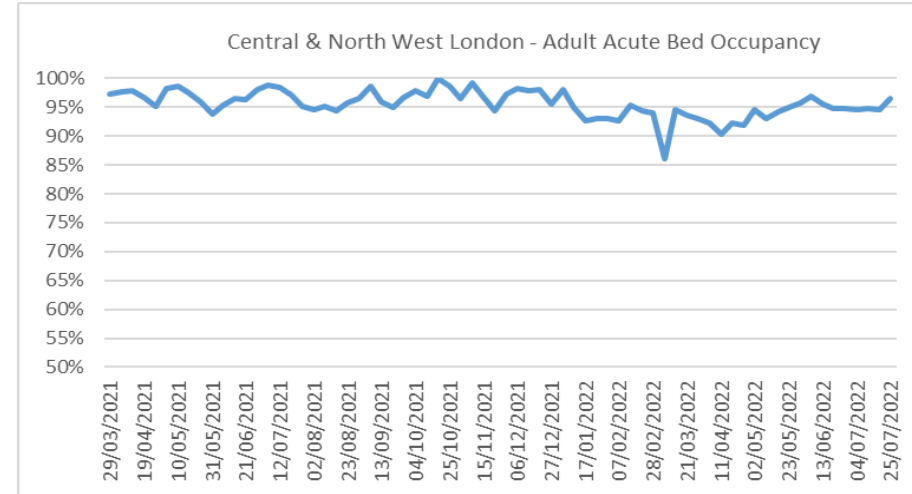
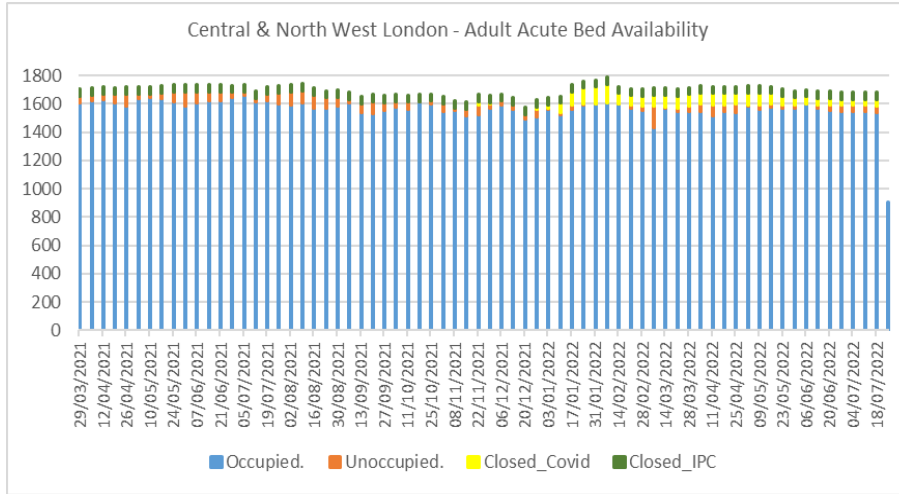


Note: CNWL are reporting all activity from Jan 2022 which has resulted in increase

NWL System: Mental Health Adult Acute Bed Usage

Source: Daily SitReps

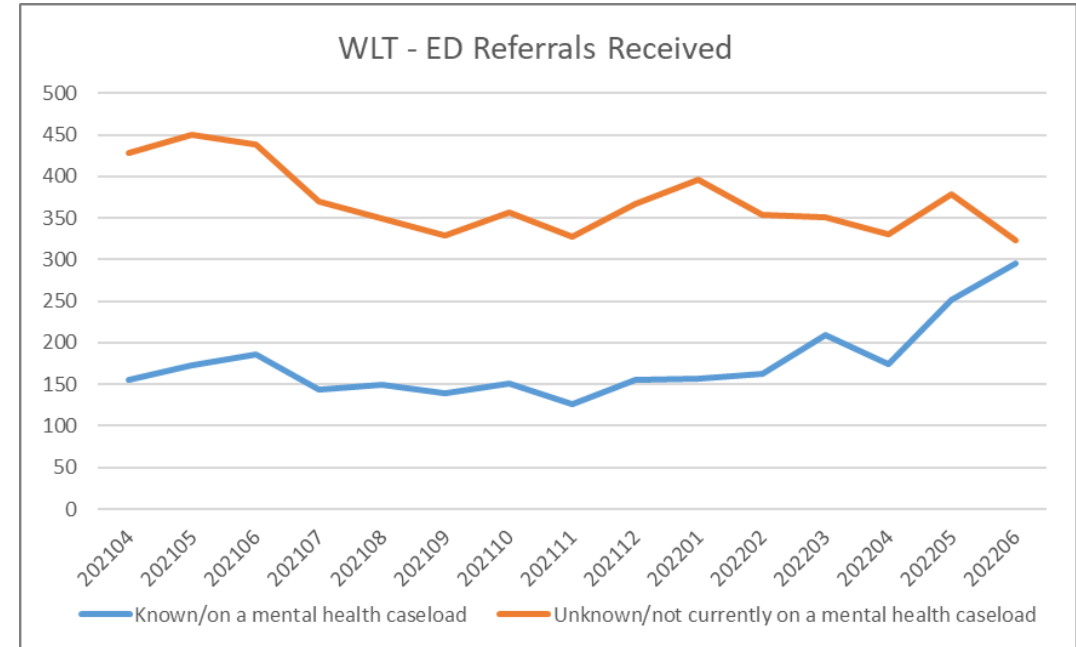
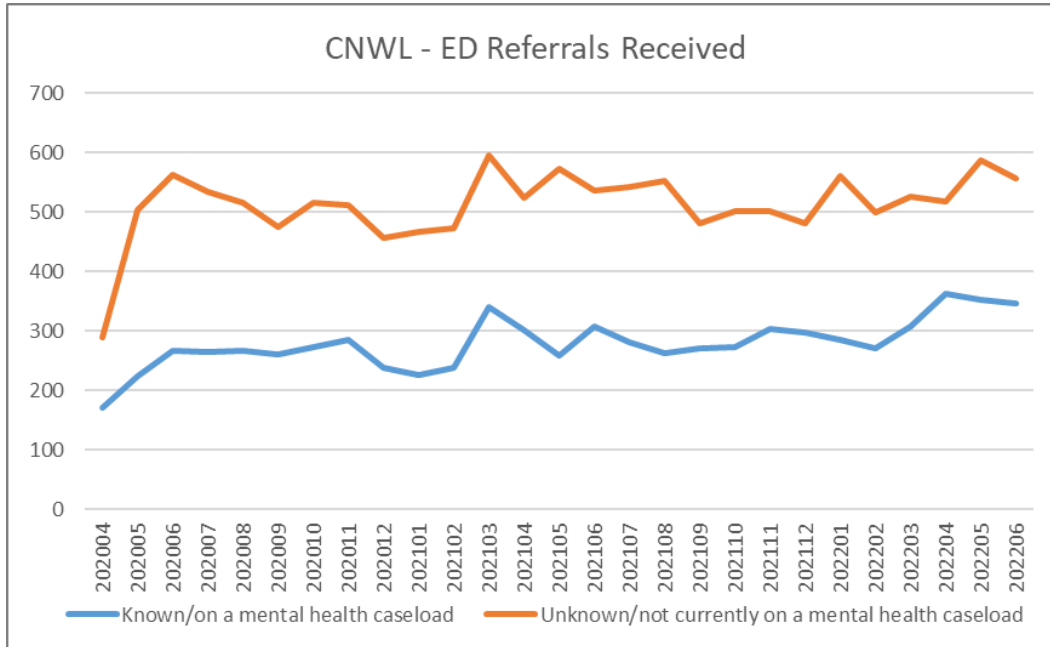
Latest data up to: 25/07/2022



NWL System: Mental Health ED Referrals to LPS Service

Source: LPS Patient Level Dataset

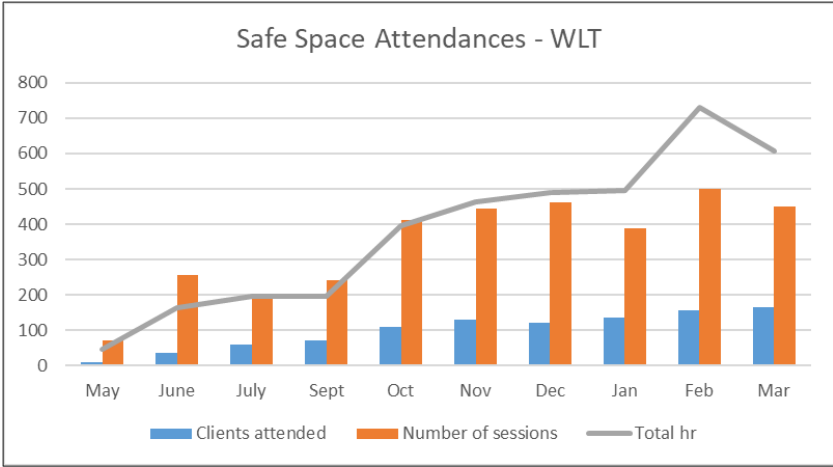
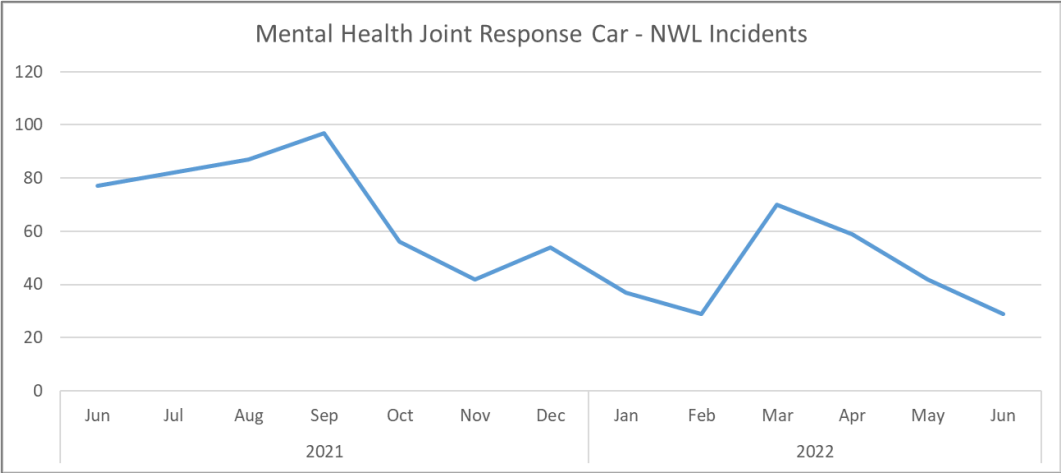
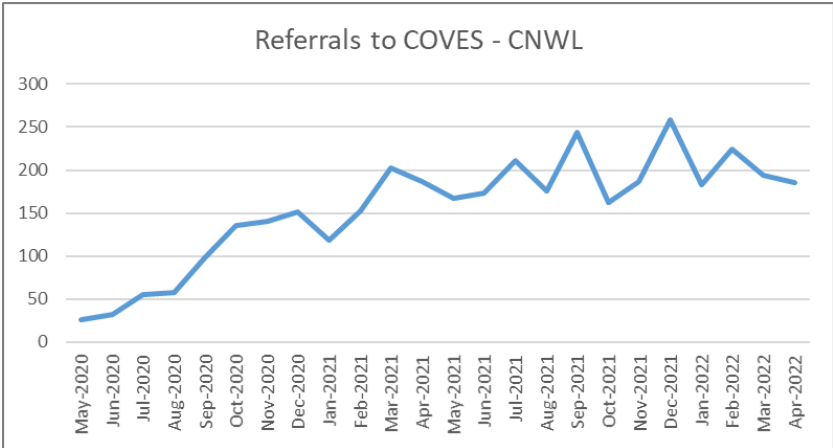
Data to: Jun-22



NWL System: Mental Health – Crisis Alternatives

Source: LAS report - Mental Health Joint Response Car

Latest data up to: 30/06/2022



RM Partners

West London Cancer Alliance

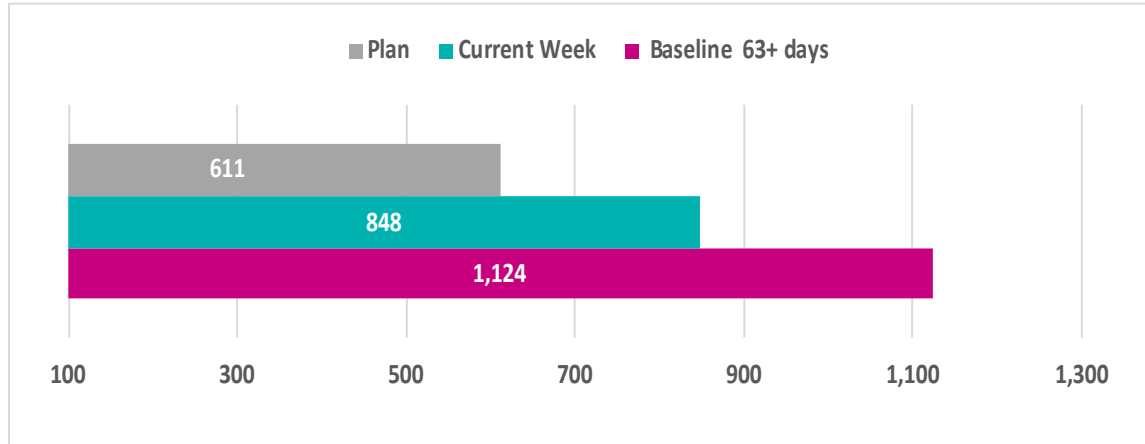
Hosted by The Royal Marsden NHS Foundation Trust

North West London PTL and TWW first seen

W/E 28/08/2022

*Working in partnership, **we will achieve world class cancer outcomes** for the population we serve*

Urgent Suspected Cancer 63+ Days



Patients Waiting 63+ Days: Split By Referral

Referral Route	Current Week	Previous Week	Change From Previous Week	% Change From Previous Week
Urgent Suspected Cancer	848	835	+13	+2%
Consultant Upgrade	157	139	+18	+13%
Urgent Breast Symptomatic	19	11	+8	+73%
Urgent Bowel Screening	17	11	+6	+55%
Urgent Breast Screening	52	35	+17	+49%
Urgent Cervical Screening	12	16	-4	-25%
Grand Total	1,105	1047	+58	+6%

Urgent Suspected Cancer

63 Day Backlog NWL - 848

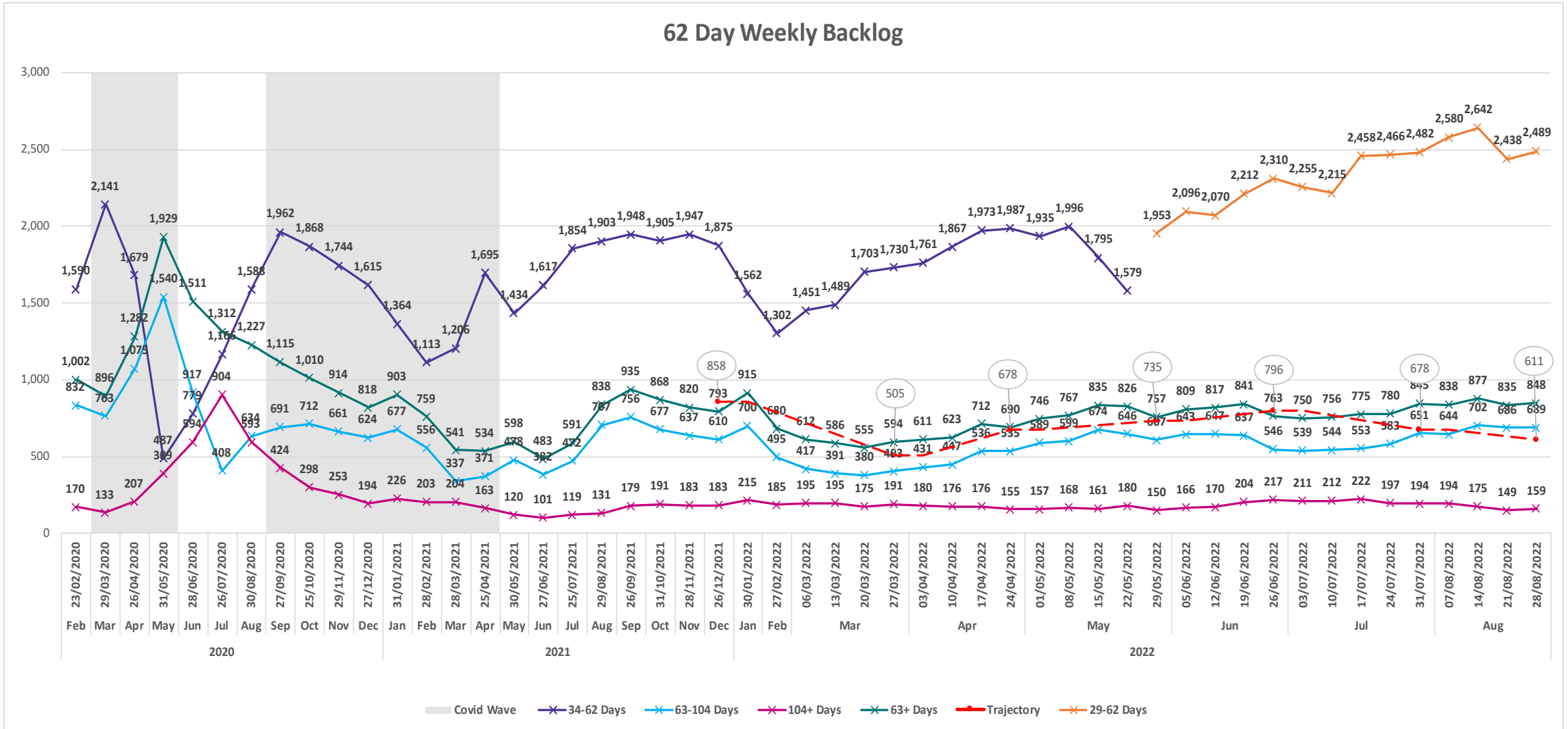


Trust	Current Week			% Change From Previous Week			% Change From Baseline		
	63-104 Days	104+ Days	63+ Days	63-104 Days	104+ Days	63+ Days	63-104 Days	104+ Days	63+ Days
NORTH WEST LONDON HEALTH & CARE PARTNERSHIP	689	159	848	+0%	+7%	+2%	-26%	-20%	-25%
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	122	31	153	-5%	+29%	+1%	-49%	-63%	-53%
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	282	88	370	+18%	+16%	+17%	-22%	+83%	-10%
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	209	32	241	-12%	-24%	-14%	-27%	-52%	-32%
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	76	8	84	-6%	+14%	-5%	+111%	+700%	+127%
NWL	689	159	848	+0%	+7%	+2%	-26%	-20%	-25%

Baseline as at 16/02/2020

NWL PTL Urgent Referrals Overview 62 Days Pathway

W/E 28/08/2022



Collated by RM Partners Informatics Team

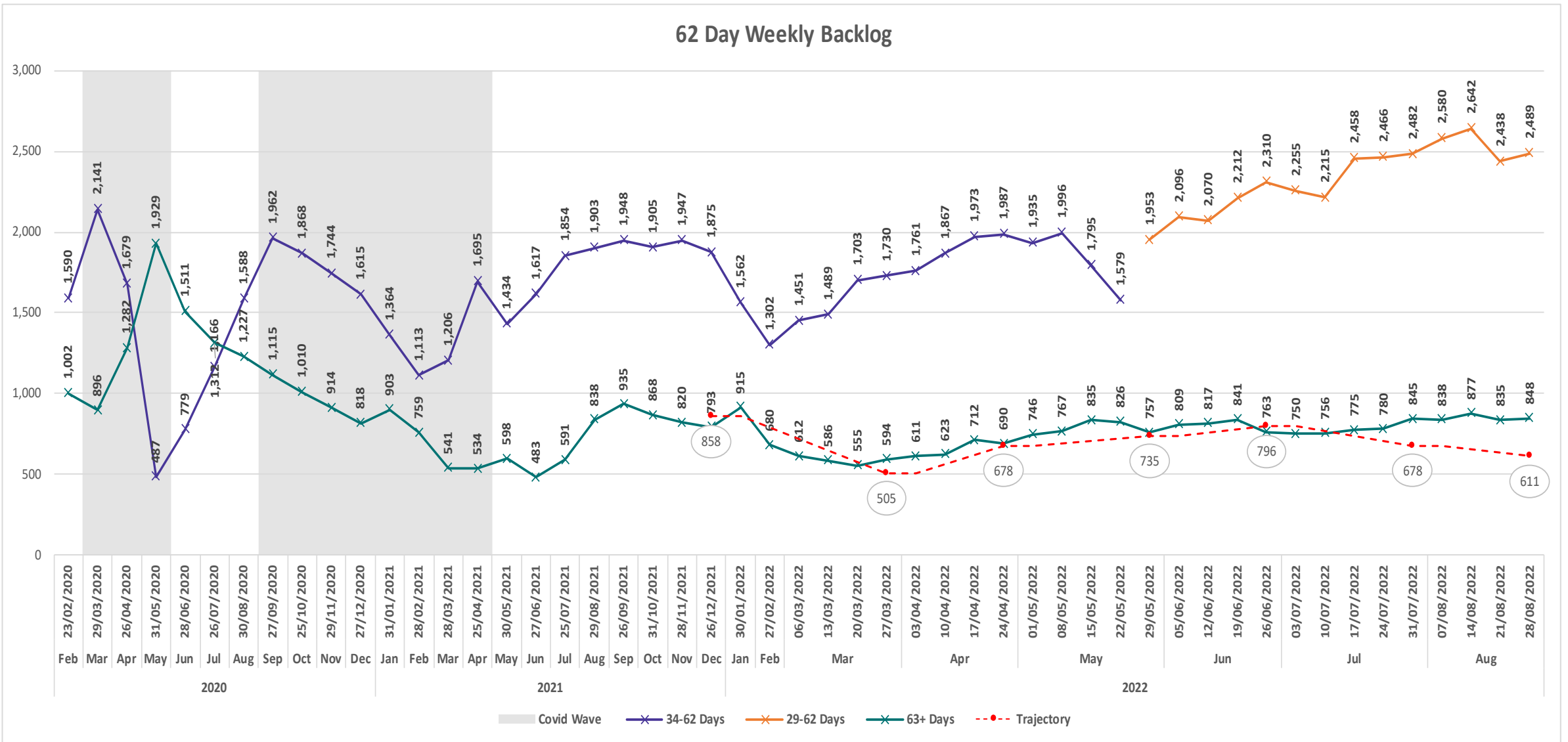
Contact - rmpartners.informatics@nhs.net

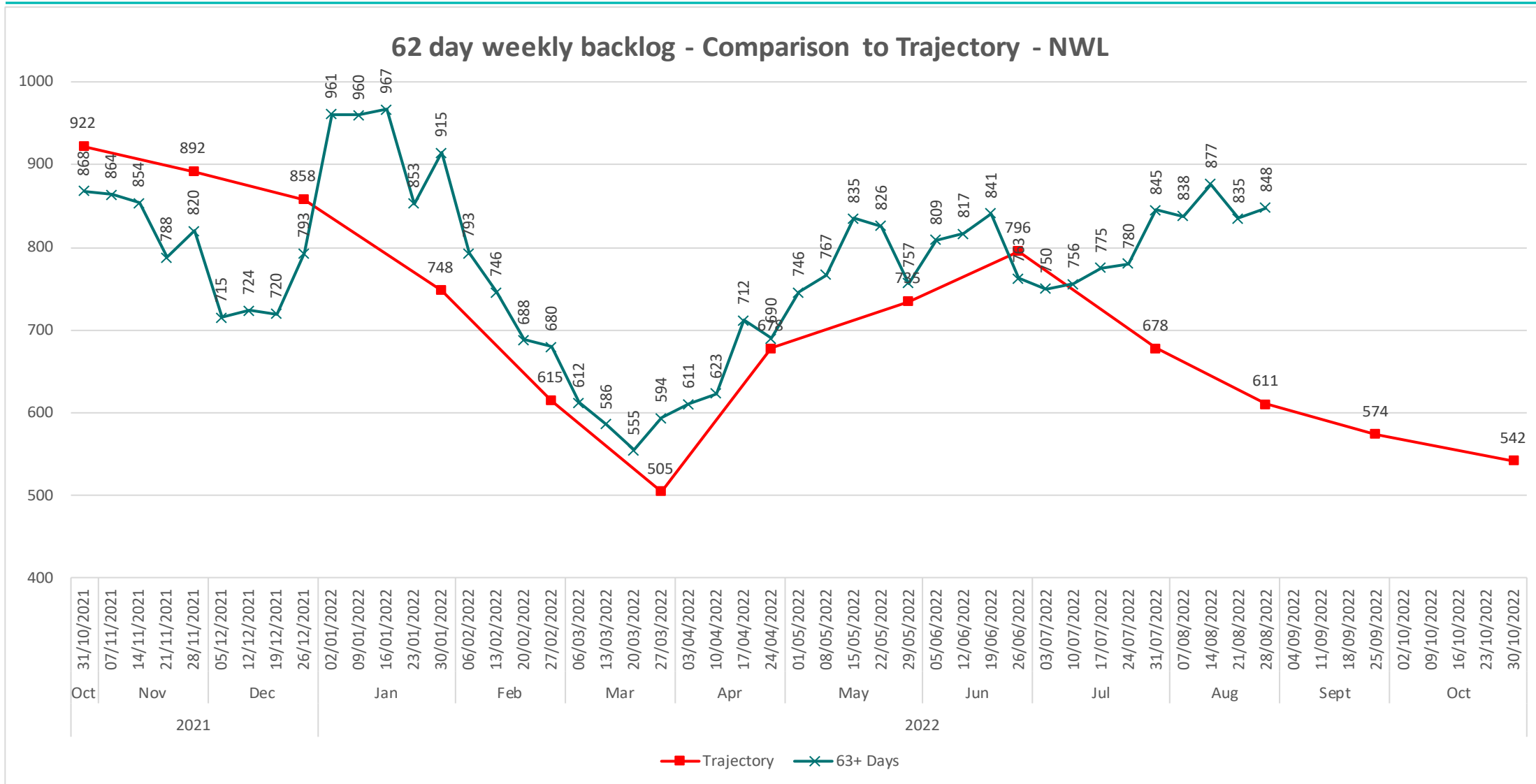
For NHS internal use only

NWL PTL Urgent Referral Cases

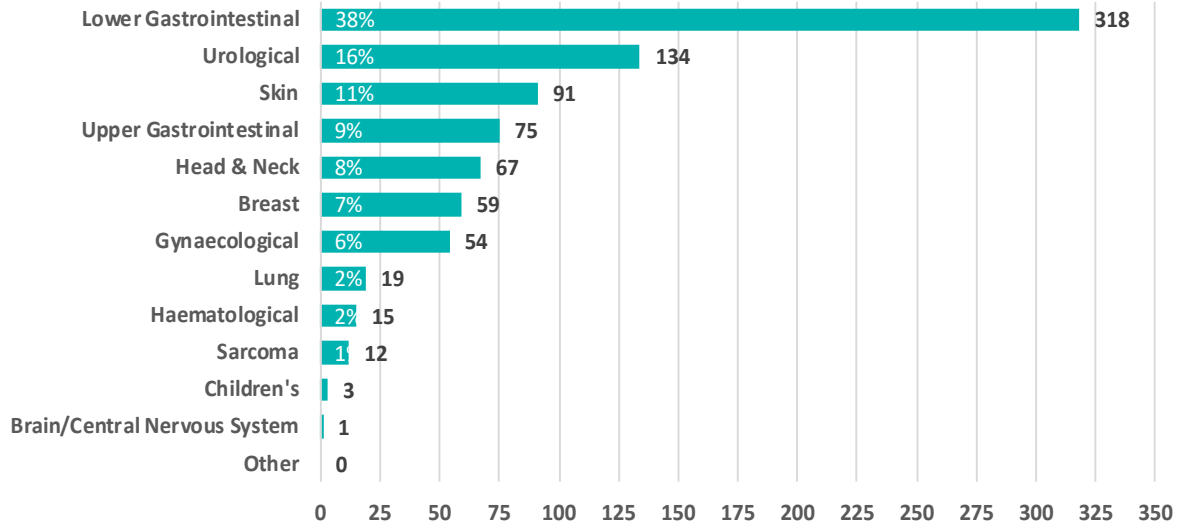
W/E 28/08/2022

62 Day Weekly Backlog

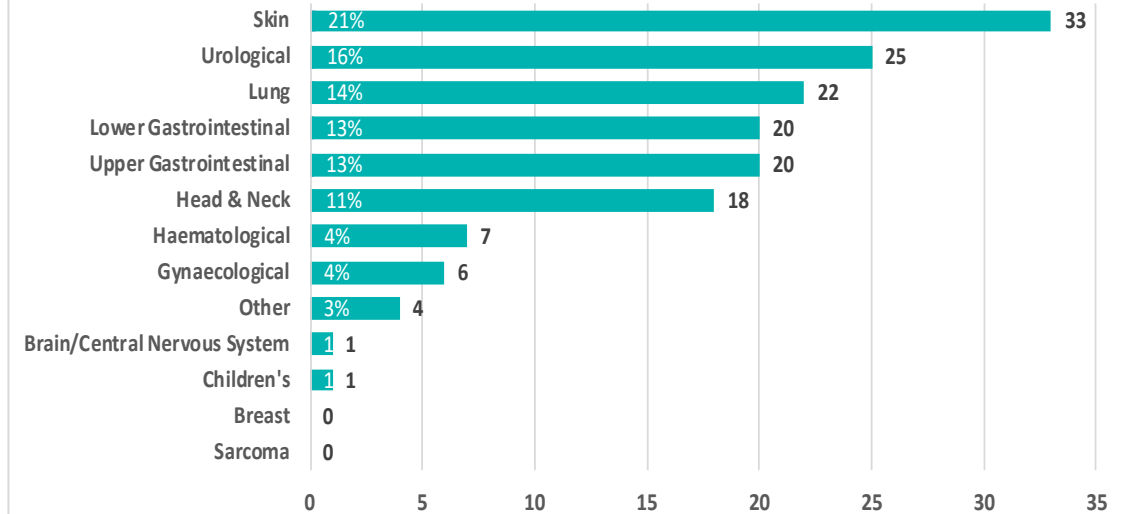




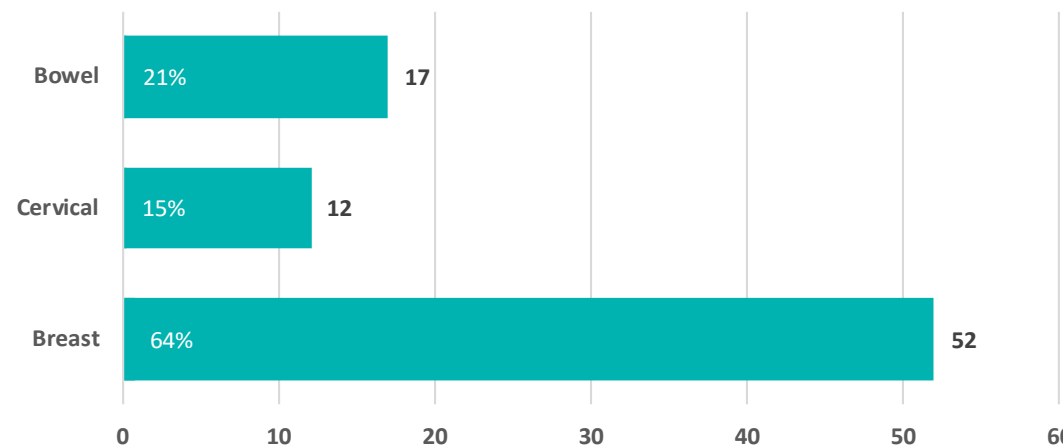
Urgent Suspected Cancer Referrals



Consultant Upgrades

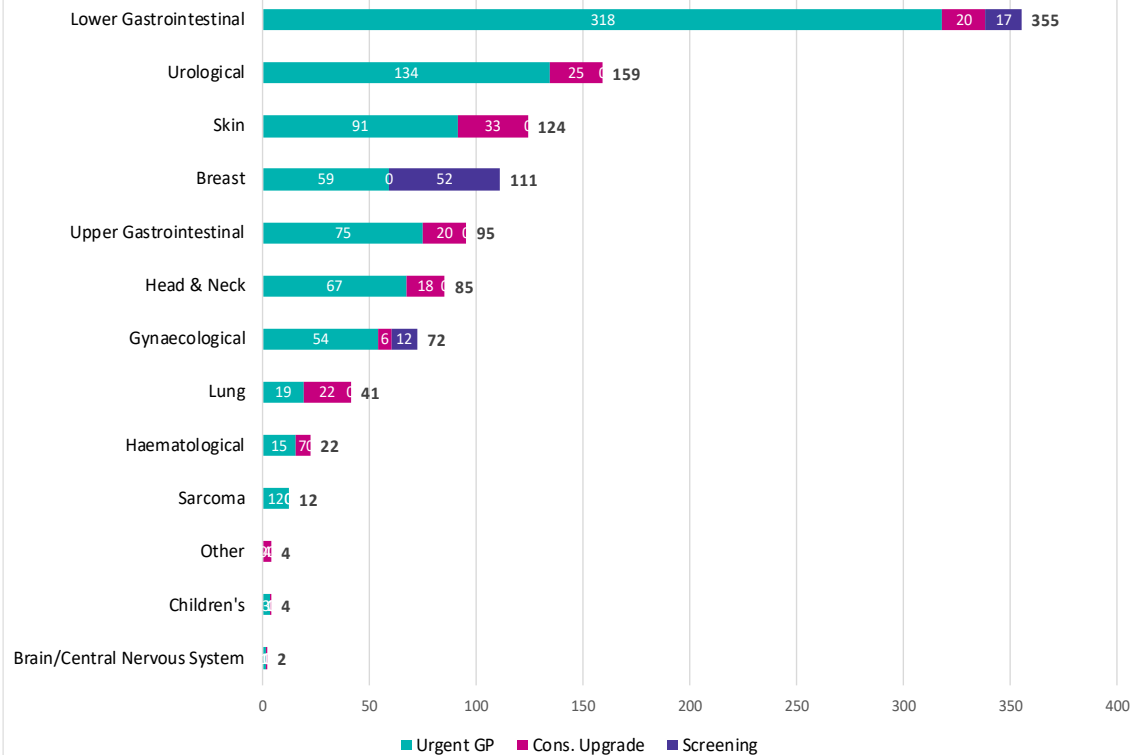


Screening (Breast, Bowel, & Cervical)



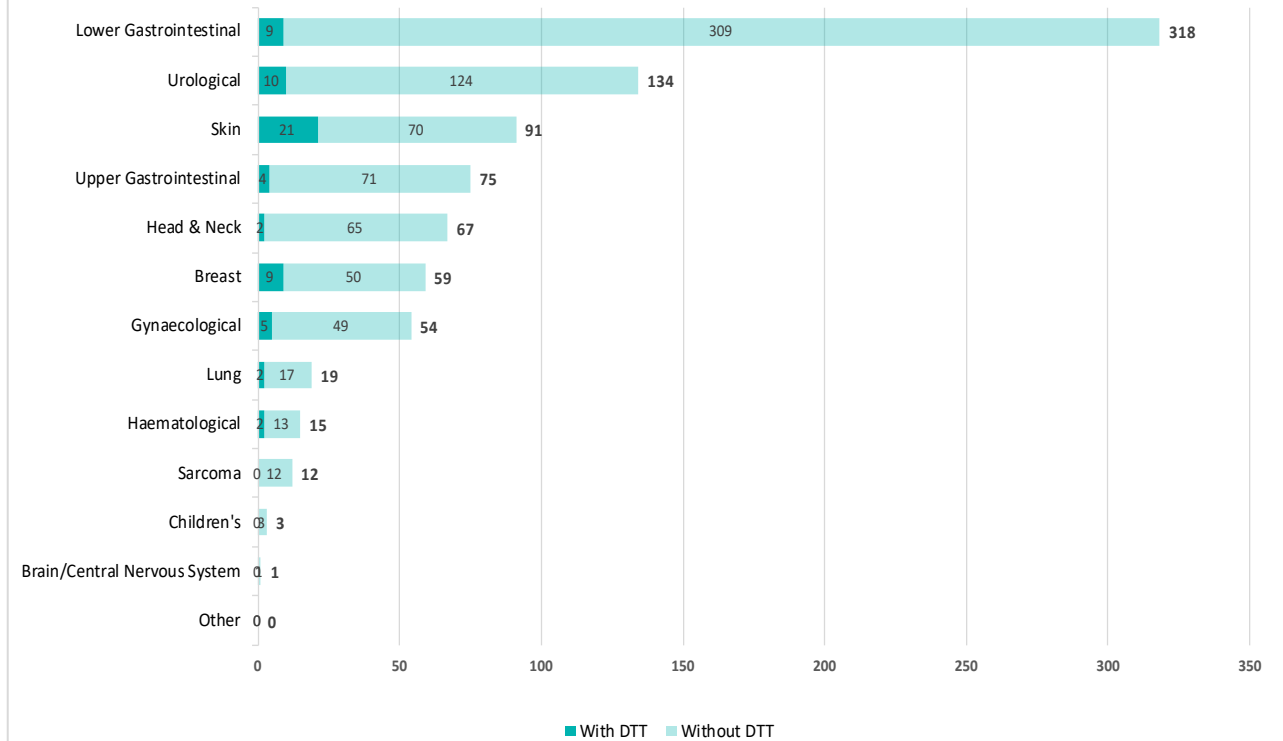
All Referral Routes

Patients Waiting 63+ days by Referral Route



Urgent Suspected Cancer

Patients Waiting 63+ Days With and Without Decision to Treat

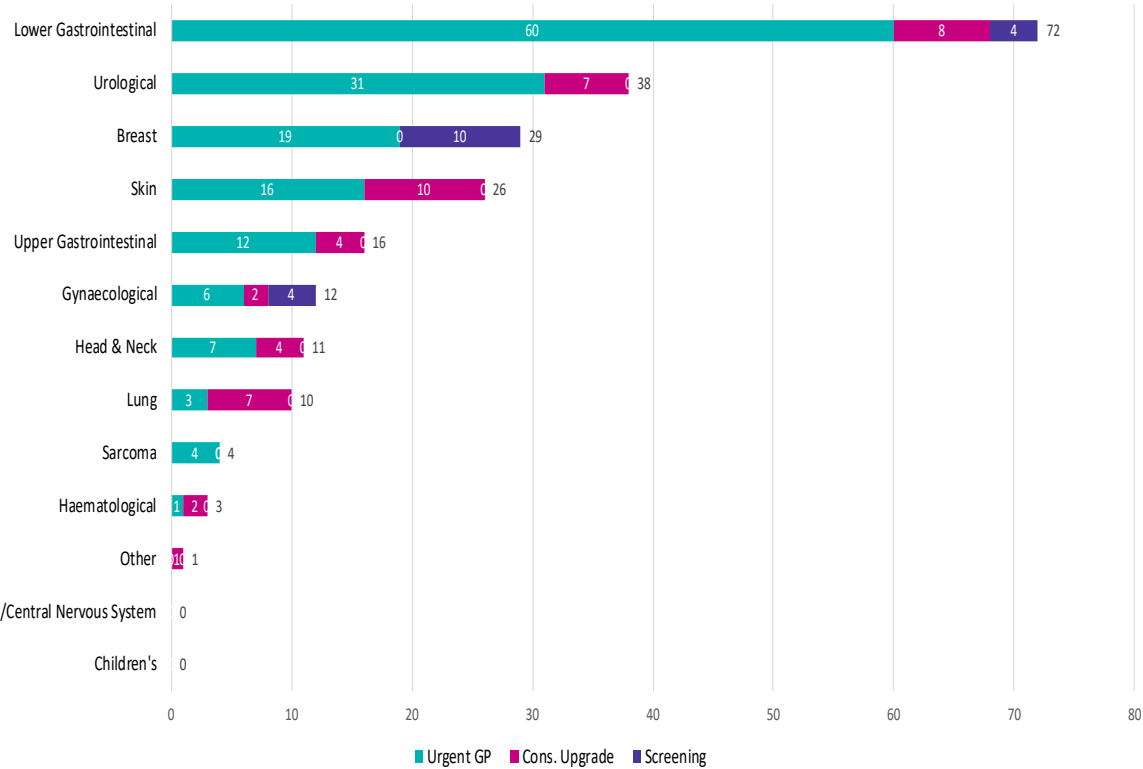


Change From Previous Week

Referral Route	Brain/Central Nervous System	Breast	Children's	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Grand Total
Urgent Suspected Cancer	+1	+1	-2	+7	+3	+1	+31	+1	0	+5	-11	-19	-5	+13
Consultant Upgrade	+1	0	-1	+2	0	-1	-2	+2	+4	0	+2	+2	+9	+18
Urgent Bowel Screening							+6							+6
Urgent Breast Screening		+17												+17
Urgent Cervical Screening				-4										-4
Grand Total	+2	+18	-3	+5	+3	0	+35	+3	+4	+5	-9	-17	+9	+50

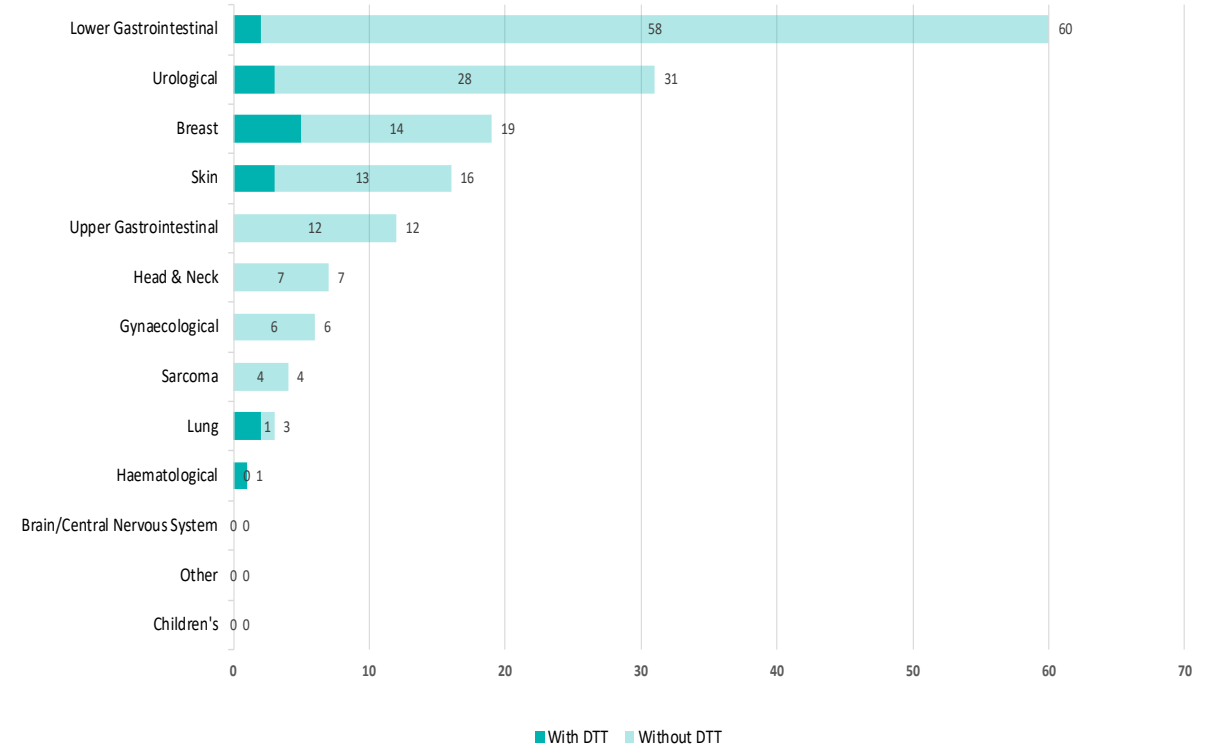
All Referral Routes

Patients Waiting 104+ days by Referral Route



Urgent Suspected Cancer

Patients Waiting 104+ Days With and Without Decision to Treat

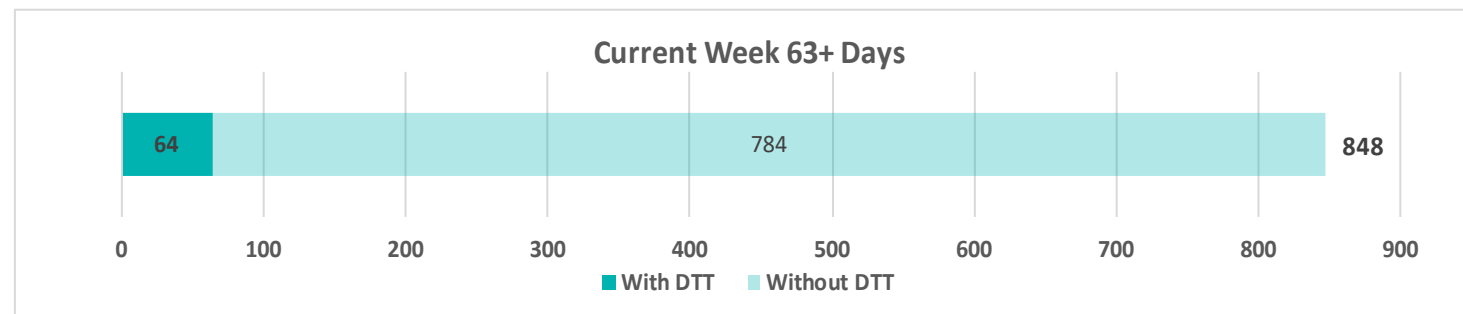


Change From Previous Week

Referral Route	Brain/Central Nervous System	Breast	Children's	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Grand Total
Urgent Suspected Cancer	0	+2	0	-2	-1	+2	+6	+2	0	+1	+3	-6	+3	+10
Consultant Upgrade	0	0	0	-1	-1	0	+2	0	+1	0	+4	-3	+2	+4
Urgent Bowel Screening							+1							+1
Urgent Breast Screening		+5												+5
Urgent Cervical Screening				-1										-1
Grand Total	0	+7	0	-4	-2	+2	+9	+2	+1	+1	+7	-9	+5	+19

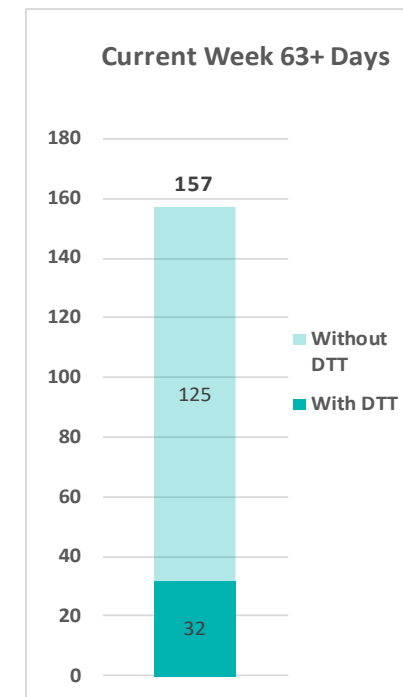
Urgent Suspected Cancer

Tumour Type	07/08/2022		14/08/2022		21/08/2022		28/08/2022	
	63+ Days	% of total	63+ Days	% of total	63+ Days	% of total	63+ Days	% of total
Lower Gastrointestinal	284	34%	312	36%	287	34%	318	38%
Urological	128	15%	147	17%	139	17%	134	16%
Skin	89	11%	103	12%	102	12%	91	11%
Upper Gastrointestinal	90	11%	90	10%	94	11%	75	9%
Head & Neck	76	9%	70	8%	66	8%	67	8%
Breast	82	10%	68	8%	58	7%	59	7%
Gynaecological	50	6%	48	5%	47	6%	54	6%
Lung	13	2%	17	2%	18	2%	19	2%
Haematological	8	1%	8	1%	12	1%	15	2%
Sarcoma	11	1%	11	1%	7	1%	12	1%
Children's	7	1%	3	0%	5	1%	3	0%
Brain/Central Nervous System	0	0%	0	0%	0	0%	1	0%
Other	0	0%	0	0%	0	0%	0	0%
Grand Total	838	100%	877	100%	835	100%	848	100%



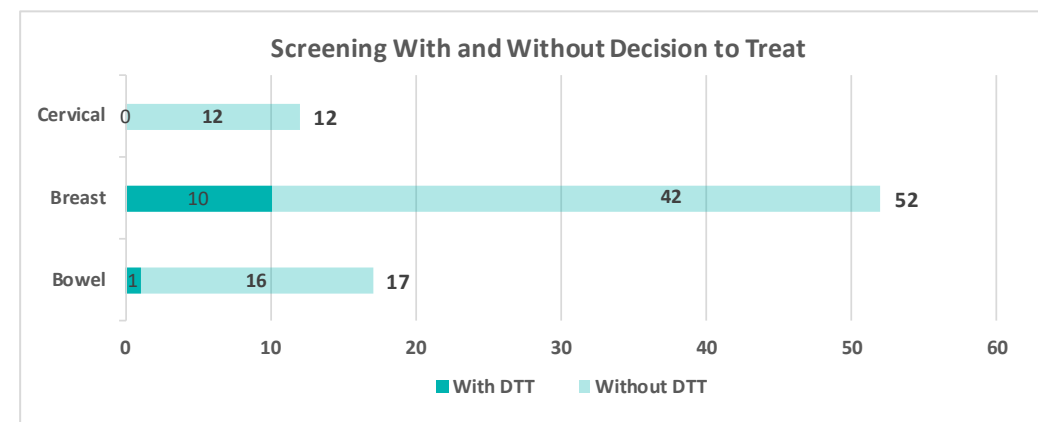
Consultant Upgrades

Tumour Type	07/08/2022		14/08/2022		21/08/2022		28/08/2022	
	63+ Days	% of total	63+ Days	% of total	63+ Days	% of total	63+ Days	% of total
Skin	36	23%	31	19%	31	22%	33	21%
Urological	24	16%	27	17%	16	12%	25	16%
Lung	22	14%	28	17%	20	14%	22	14%
Lower Gastrointestinal	26	17%	25	16%	22	16%	20	13%
Upper Gastrointestinal	12	8%	15	9%	18	13%	20	13%
Head & Neck	17	11%	20	12%	19	14%	18	11%
Haematological	5	3%	5	3%	7	5%	7	4%
Gynaecological	5	3%	6	4%	4	3%	6	4%
Other	0	0%	0	0%	0	0%	4	3%
Brain/Central Nervous System	1	1%	0	0%	0	0%	1	1%
Children's	2	1%	2	1%	2	1%	1	1%
Breast	2	1%	2	1%	0	0%	0	0%
Sarcoma	2	1%	0	0%	0	0%	0	0%
Grand Total	154	100%	161	100%	139	100%	157	100%



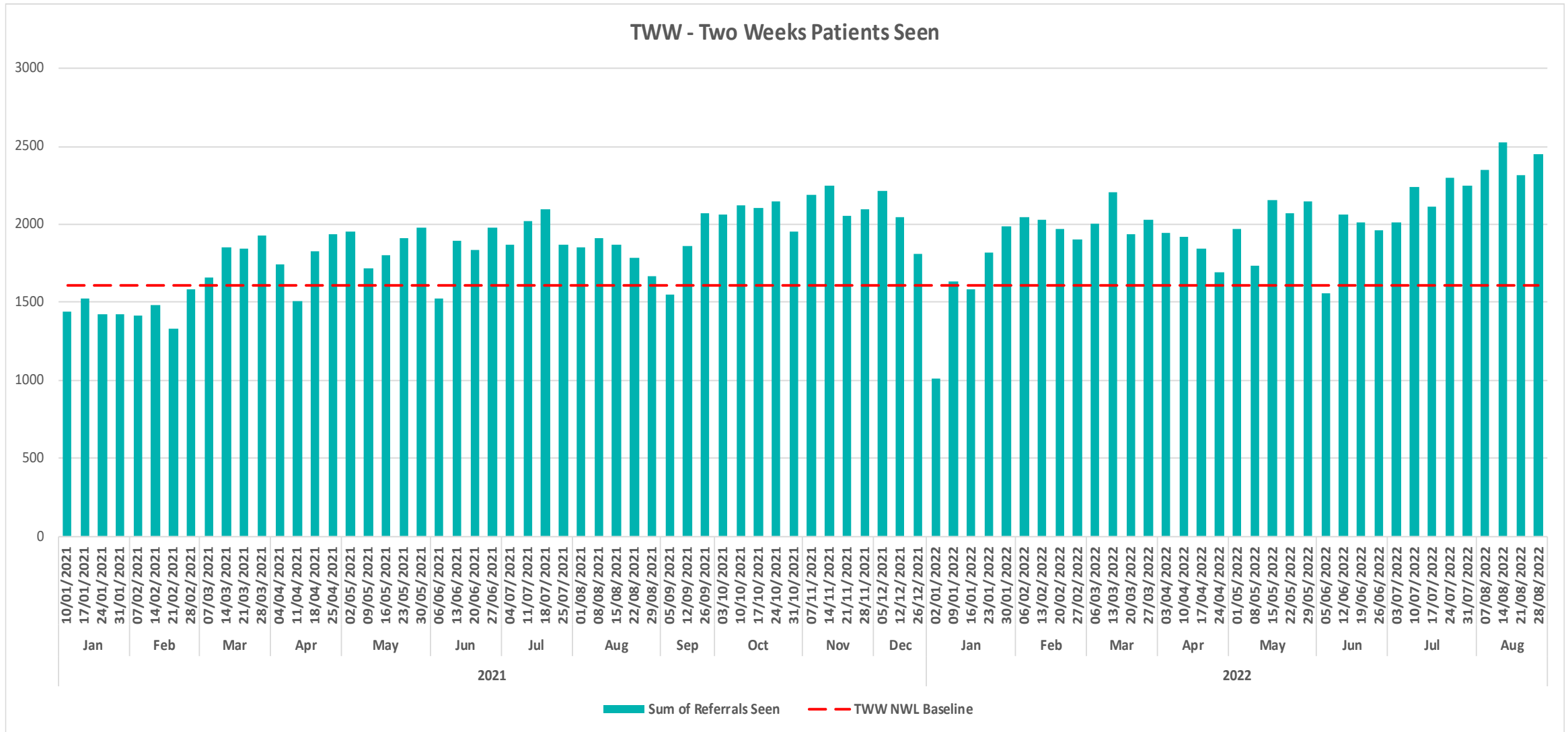
Screening

Date	Breast		Cervical		Bowel	
	63+ Days	% of total	63+ Days	% of total	63+ Days	% of total
28/08/2022	52	64%	12	15%	17	21%
21/08/2022	35	56%	16	26%	11	18%
14/08/2022	37	56%	18	27%	11	17%
07/08/2022	33	42%	32	41%	14	18%
Grand Total	157	55%	78	27%	53	18%



TWW Patients Seen (Weekly)

NWL - TWW Patients Seen (Weekly)



Please note - From **w/e 29.05.2022** the 2WW numbers were added to the PTL national submissions under Section 5. In the WAR TWW submission **symptomatic breast** patients were being included for some trusts incorrectly. With PTL submission this is now corrected, from **w/e 29.05.22** onwards should now reflect accurate position.

NWL - TWW Patients Seen (Weekly)

Suspected Cancer Type	Baseline 19/20	12/06/2022	19/06/2022	26/06/2022	03/07/2022	10/07/2022	17/07/2022	24/07/2022	31/07/2022	07/08/2022	14/08/2022	21/08/2022	28/08/2022	Trend
Brain/Central Nervous System	14	12	19	11	17	13	13	16	12	11	17	13	14	
Breast	285	367	412	419	351	424	440	420	380	425	394	408	410	
Children's	12	97	10	11	10	13	17	11	17	10	18	9	12	
Gynaecological	169	296	264	294	224	267	224	257	282	265	273	243	286	
Haematological	25	31	16	19	18	23	19	22	28	27	27	16	25	
Head & Neck	173	198	231	200	235	278	228	195	209	309	242	244	341	
Lower Gastrointestinal	323	331	372	345	372	380	321	497	466	404	532	384	358	
Lung	49	32	36	44	24	39	32	34	36	33	39	46	40	
Other	0	1	0	0	3	0	0	0	3	6	1	2	4	
Sarcoma	0	1	6	4	6	5	3	4	13	13	2	3	3	
Skin	296	367	333	294	375	458	513	480	444	460	570	555	562	
Upper Gastrointestinal	118	136	142	154	134	155	124	163	132	129	193	182	156	
Urological	142	191	173	170	244	185	182	201	229	254	216	214	237	
Total	1,607	2060	2014	1965	2013	2240	2116	2300	2251	2346	2524	2319	2448	

28/08/2022	
Tumour Site	% From Baseline
Brain/Central Nervous System	100%
Breast	144%
Children's	100%
Gynaecological	169%
Haematological	100%
Head & Neck	197%
Lower Gastrointestinal	111%
Lung	82%
Other	
Sarcoma	
Skin	190%
Upper Gastrointestinal	132%
Urological	167%
Total	152%

>100% within baseline
>=90% within baseline
>=70% within baseline
>=50% within baseline
<50% from baseline

Please note - From **w/e 29.05.2022** the 2WW numbers were added to the PTL national submissions under Section 5. In the WAR TWW submission **symptomatic breast** patients were being included for some trusts incorrectly. With PTL submission this is now corrected, from **w/e 29.05.22** onwards should now reflect accurate position.

NWL – Monthly

Suspected Tumour Type	2022											
	JAN		FEB		MAR		APR		MAY		JUN	
	No. 1st Seen	% compared to 2019	No. 1st Seen	% compared to 2019	No. 1st Seen	% compared to 2019	No. 1st Seen	% compared to 2019	No. 1st Seen	% compared to 2019	No. 1st Seen	% compared to 2019
Acute leukaemia	3	43%	4	67%	8	200%	3	75%	4	133%	3	100%
Brain/Central Nervous System	52	106%	60	94%	75	147%	60	90%	80	148%	57	133%
Breast	1,153	88%	1,201	98%	1,321	105%	1,014	75%	1,371	111%	1,483	98%
Children's	42	81%	86	154%	98	228%	66	135%	83	122%	68	128%
Gynaecological	811	124%	929	124%	1,117	158%	587	76%	1,030	136%	1,075	147%
Haematological	81	73%	93	82%	77	76%	75	66%	116	97%	94	90%
Head & Neck	684	94%	775	99%	1,049	141%	765	88%	1,039	128%	807	112%
Lower Gastrointestinal	1,181	75%	1,166	80%	1,522	108%	922	60%	1,345	84%	1,697	116%
Lung	162	71%	170	97%	182	71%	135	61%	176	83%	145	67%
Other	12	600%	5	250%			3	300%	3	300%	4	400%
Sarcoma	5	100%	13	186%	14		1		16		13	
Skin	1,156	94%	1,364	122%	1,622	134%	968	81%	1,643	119%	1,522	116%
Testicular	35	73%	43	110%	51	142%	29	78%	38	88%	41	146%
Upper Gastrointestinal	523	111%	625	147%	685	156%	423	89%	710	173%	712	158%
Urological	703	114%	828	127%	958	166%	589	94%	883	154%	849	149%
Total	6,603	93%	7,362	107%	8,779	128%	5,640	77%	8,537	117%	8,570	119%

RAG Rating
>=100%
>=90%
>=70%
>=50%
<50%



Chelsea and Westminster Hospital
NHS Foundation Trust



The Hillingdon Hospitals
NHS Foundation Trust



Imperial College Healthcare
NHS Trust



London North West
University Healthcare
NHS Trust

NWL Acute Provider Collaborative Clinical Outcomes Workstream

Executive Summary

Executive Summary:

The quality metrics were agreed following a detailed review of the trust board scorecards, national guidance and CQC insight reports. Reporting methodology has been agreed however trusts have not always reported in this way meaning there are gaps in the available data which will be addressed for the next dashboard. Statistical process control (SPC) charts have been used as standard. This has not been in place in all trusts and so will take time to embed. The SPC's in this first round give data for each trust to compare over time however they are not as useful for comparing cross trust, a key requirement for the board in common. To enable this the data will be reviewed at the weekly quality meeting chaired by Professor Tim Orchard, CEO lead for quality. Targets where appropriate and improvement trajectories will be confirmed and data compared which will then inform the dashboards for the next reporting cycle. Comparison using activity, whole time equivalent numbers and response numbers may help the data become more meaningful and is being considered for example in the patient experience metrics. The scales on the SPC charts need to be consistent even although the control limits may be different for each trust.

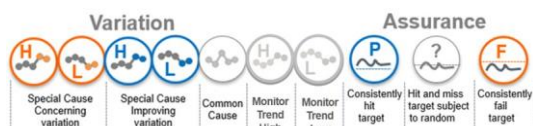
The dashboard was not available for presentation to the individual trust quality committee's and so a bespoke process was used to allow presentation to this board in common. A process was approved at the Acute collaborative quality committee which will address this with the dashboard a key part of the trust quality function reports presented there which will allow variance and improvement reporting.

Five priority work streams for quality have been agreed across the collaborative. A key part of these is to determine how we measure and report clinical outcomes. The outputs from these work streams will be reviewed alongside the dash board metrics at the collaborative quality committee in March with any recommendations to amend the dash board in advance of the new financial year.

Escalations by Theme:

Clinical Outcomes Scorecard

POD	Clinical Outcome Metrics		Variation				Assurance			
	Metric ID	Metric	CWFT	ICHT	THH	LNW	CWFT	ICHT	THH	LNW
1	Clinical / Quality	Number of patient safety incidents								
2	Clinical / Quality	Reporting rate of patient safety incidents								
3	Clinical / Quality	% of patient safety incidents graded severe/major harm*								
4	Clinical / Quality	% of patient safety incidents graded extreme harm/death*								
5	Clinical / Quality	Number SI declared								
6	Clinical / Quality	Never Events	n/a	n/a	n/a	n/a				
7	Clinical / Quality	C.Diff (Combined position)								
8	Clinical / Quality	E.coli blood stream infection								
9	Clinical / Quality	MRSA Bacteraemia (Trust)								
10	Clinical / Quality	Complaints received: Count of formal complaints								
11	Clinical / Quality	Complaints received: Count of formal complaints								
12	Clinical / Quality	Complaints response performance	not reported							
13	Clinical / Quality	% good experience Trust inpatient								
14	Clinical / Quality	% good experience maternity								
15	Clinical / Quality	% good experience ED								
16	Clinical / Quality	SHMI - Using date of publication								
17	Clinical / Quality	HSMR** - Using date of publication								
18	Clinical / Quality	% VTE risks completed				not reported				not reported
19	Clinical / Quality	Palliative Care Coding rate (HSMR) - Using date of								
20	Clinical / Quality	Palliative Care Coding rate (SHMI) - Using date of								
22	Maternity	Crude still birth rate (per 1000 birth rate)								
24	Maternity	Number of neonatal intrapartum brain injuries as Avoidable Term Admissions in Neonates; proportion of babies	n/a	n/a	n/a	n/a				
26	Maternity	Neonates; proportion of babies								



Acute Provider Collaborative Summary:

All trusts have an incident reporting rate above the national average (n=xxx) although there is variation between trusts. This is a marker of safety culture and shows an opportunity for shared learning with CW having the highest rate. Work has commenced across the collaborative to tender a new incident reporting system, a key element of which will be to allow data to be extracted directly from the patient record, reducing the administrative burden for clinical teams.

When considering harm caused by incidents there is variation in control limits particularly in those causing extreme harm/death. Two trusts are seeing increases:

- ICHT is showing special cause variation in July 2022 for those causing severe/major harm. A full review of incidents has been completed with deep dives in specific specialties and action plans in place for these including in ophthalmology where a process failure has caused delays for 2 patients. Assurance was received that mitigation actions are in place including safety improvement priority programmes covering themes and serious incident investigations have started.
- CW is showing an increase in July 2022 for those causing extreme harm/death. This relates to 2 incidents being investigated as serious incidents.

Never events are occurring across all trusts in small numbers. The number is not increasing overall however ICHT reported recurrence of previous events. An assurance plan is being finalised which will report to their quality committee and will be shared across all trusts to consider as part of their audit programmes.

E-coli blood stream infections are showing increasing special cause variation, rates at CW and THH showing the same. CW remain below overall target but THH likely to breach their's. Assurance was presented of the detailed root cause analysis of all cases, areas where increases are seen have actions in place to support reduction.

MRSA bacteraemia rates are variable with an increase noted in CW in July 2022. This has been linked to MRSA screening and confirmation that treatment has been successful. Actions have been taken and the number has reduced.

Compliant response times show variation with ICHT showing the lowest rate within 40 days. Response rate measurement at that trust was changed a number of years ago when the national standard was amended to allow agreement of time with the complainant. Changes have been made to the structure and executive leadership and a review of the management of complex cases is underway. This will support improvements to timeliness going forward.

Acute Provider Collaborative Actions:

- Review of incidents causing extreme/harm death to be considered as part of the mortality review priority work stream.
- Project plan for the tender of a new incident reporting system across the acute collaborative to be confirmed and reviewed at Trust quality committee's and then included in the priority work stream for the new patient safety incident reporting framework.
- Never event assurance plan to be shared with all trusts and considered as part of audit.

Acute Provider Collaborative Assurance & Timescales for improvement

- How will this be monitored, frequency?

Acute Provider Collaborative Summary:

The experience metrics show variation in all surveys, overall, maternity and in the emergency departments. The data does not include the number of surveys nor how these are being collected. Each trust described improvement work in place including detailed plans in response to the Ockenden report for maternity and to support activity and acuity pressures. It was agreed that a specific piece of work was required to better understand how this data is being collected and importantly being used in each trust. This will report to each trust quality committee and a summary provided in the quality function reports to the next collaborative quality committee.

VTE assessment completion is showing variation between trusts and LNWH are not currently collecting this data. CW reported a specific issue with day surgery data which is not a clinical outcome risk but a reporting issue. This should be solved with data validation. THH have a target of 90% which they are meeting.

Mortality data shows that all trusts have rates below the expected rate when considering HSMR (100). When looking at SHMI which includes death within 30 days of discharge from hospital there is wider variation with THH marginally above 100, all others below. The accuracy of coding is important to ensure the mortality data is not adversely affected, palliative care is one of the codes that affects the HSMR in particular. There is variation in rates of the coding of palliative care across our trusts. The important thing is that this is accurate not that there is a target % to achieve. These issues are being reviewed as part of the mortality priority work stream.

Acute Provider Collaborative Actions:

Review of method of collecting experience survey data in all trusts – do we need to set up a T&F group to do this or will we each do it and report to the QC as above ?

Review of VTE assessment processes required at LNWH ?

Palliative care coding accuracy task and finish group being set up as part of the mortality priority work stream.

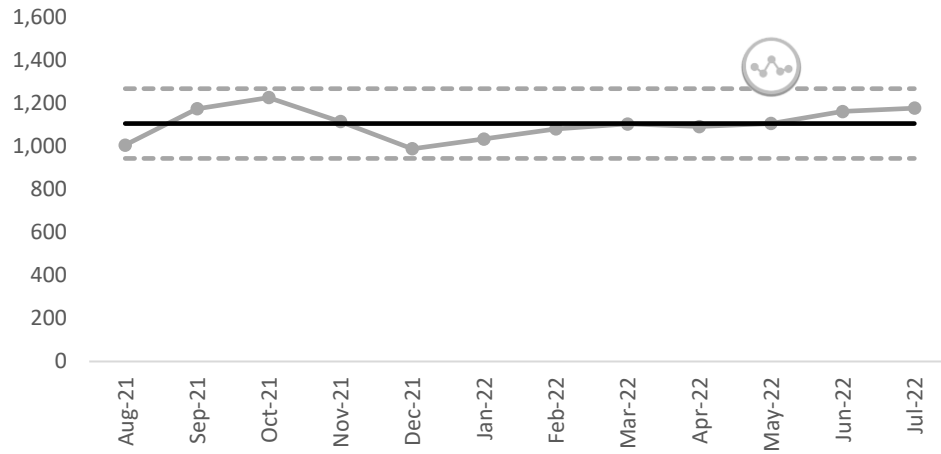
Variation at diagnostic group in SHMI & HSMR is being reviewed as part of the mortality work stream

Acute Provider Collaborative Assurance & Timescales for improvement

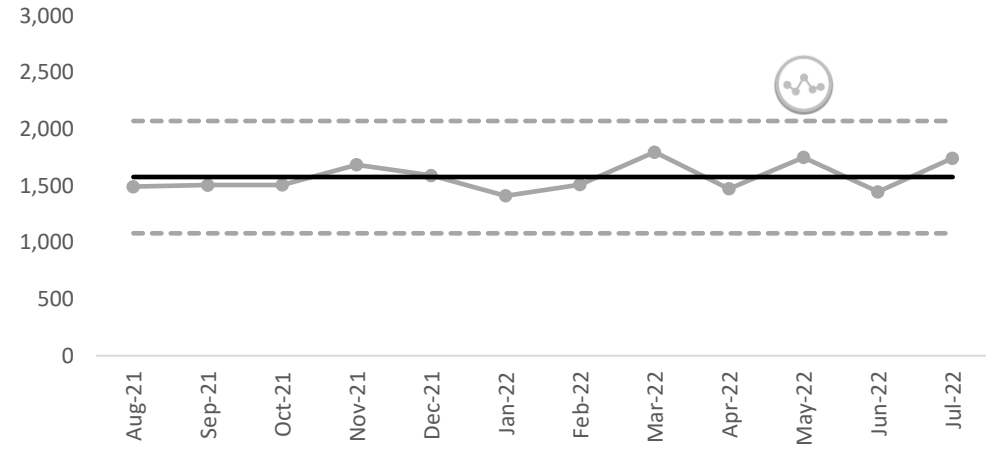
- How will this be monitored, frequency?

Metric: Number of patient safety incident
CQC Domain: Safe
Month: July 2022
Target:

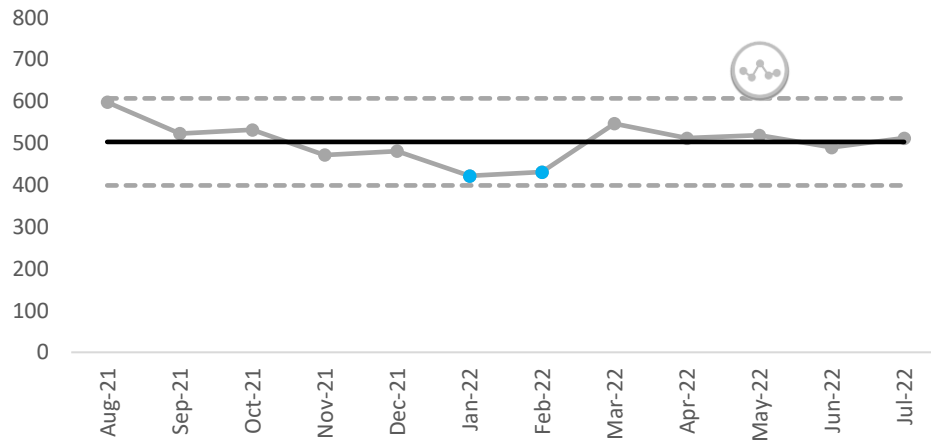
Number of patient safety incidents CW



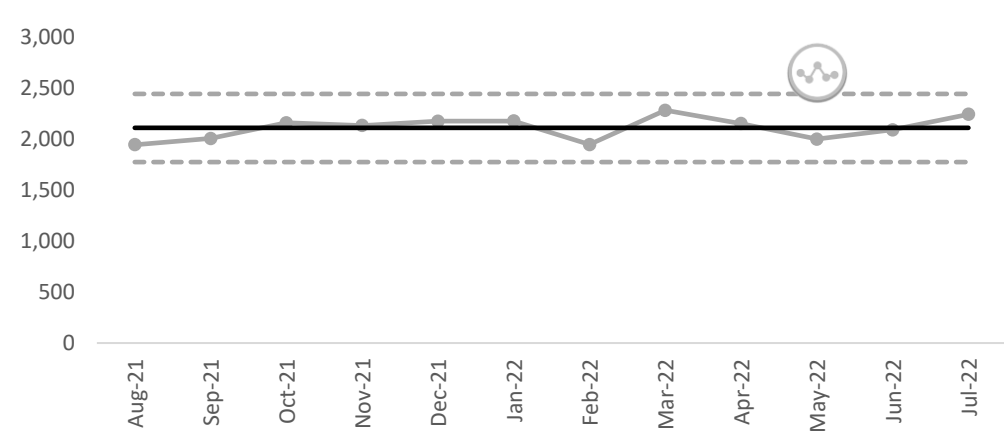
Number of patient safety incidents ICHT



Number of patient safety incidents THH

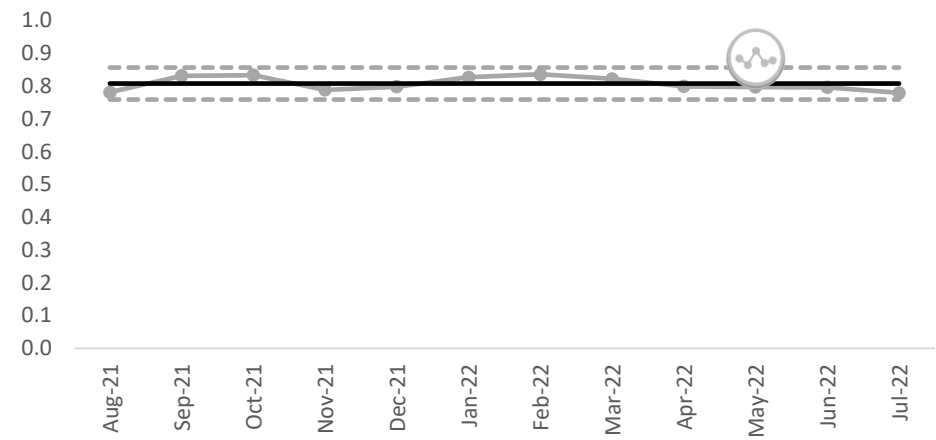


Number of patient safety incidents LNW

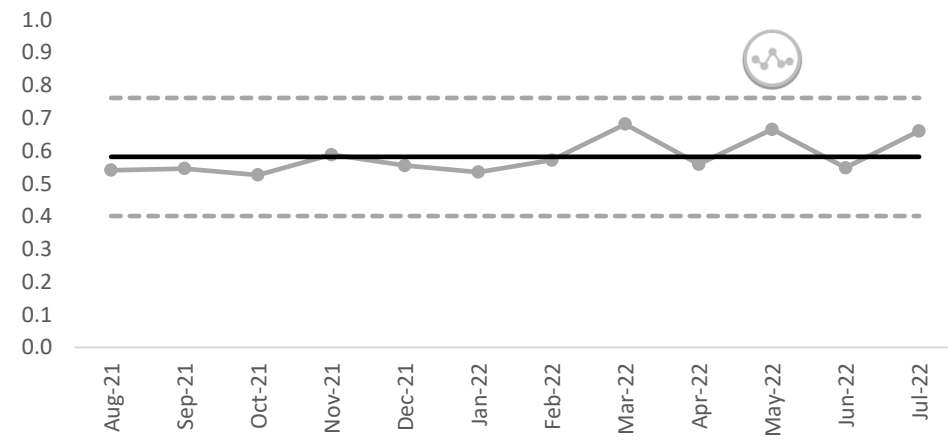


Metric: Reporting rate of patient safety incidents
CQC Domain: Safe
Month: July 2022
Target:

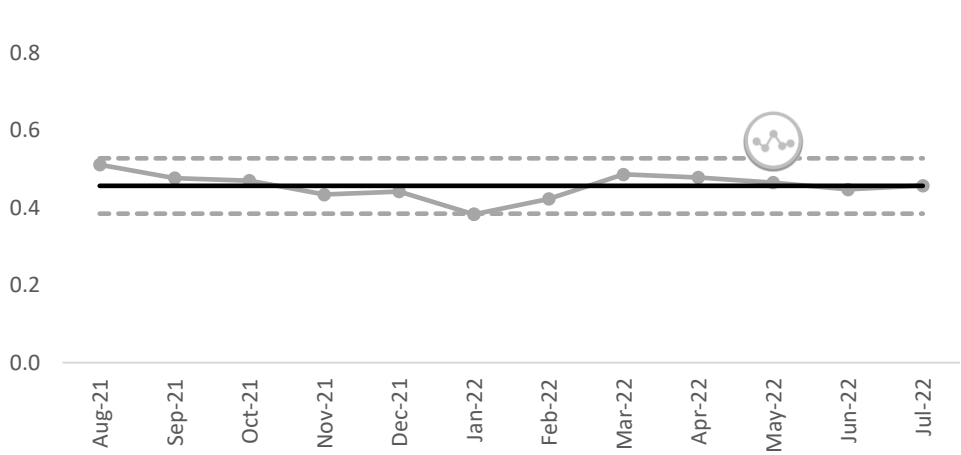
Reporting rate of patient safety incidents CW



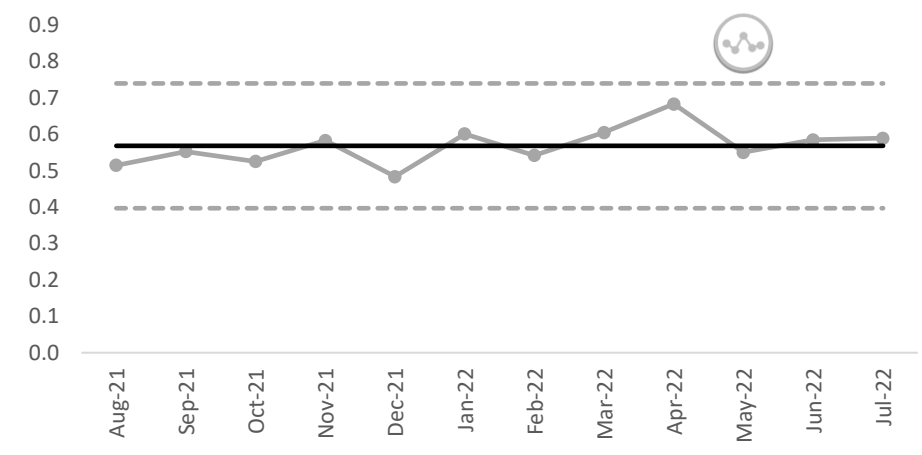
Reporting rate of patient safety incidents ICHT



Reporting rate of patient safety incidents THH

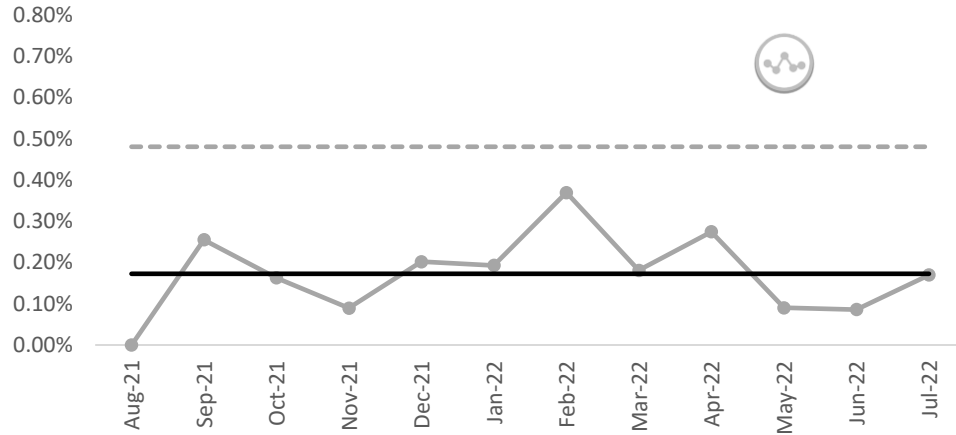


Reporting rate of patient safety incidents LNW

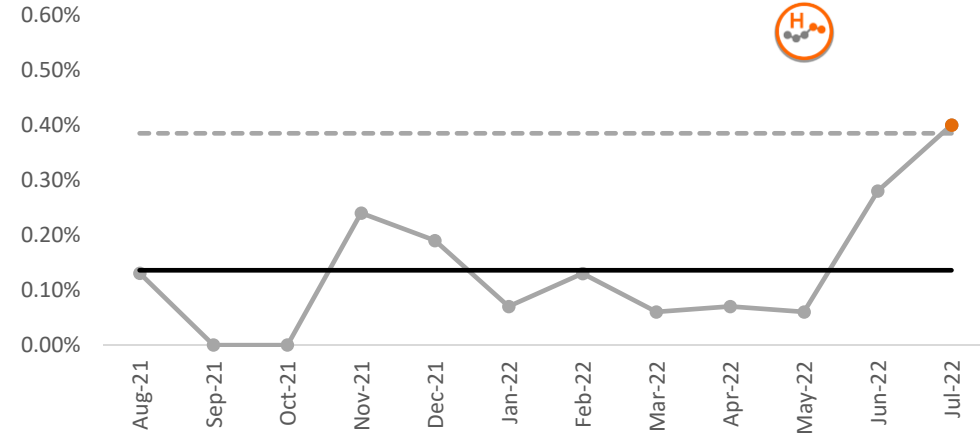


Metric: % of patient safety incidents graded severe/major harm
CQC Domain: Safe
Month: July 2022
Target:

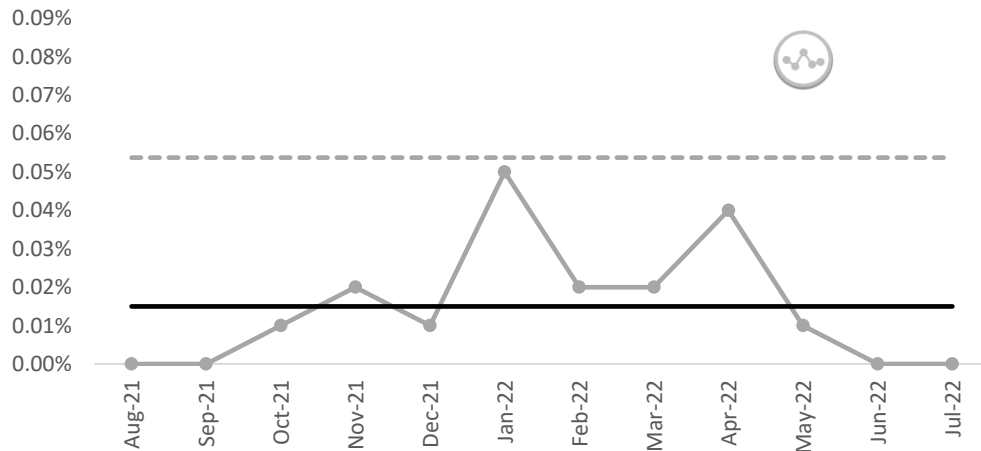
% of patient safety incidents graded severe/major harm* CW



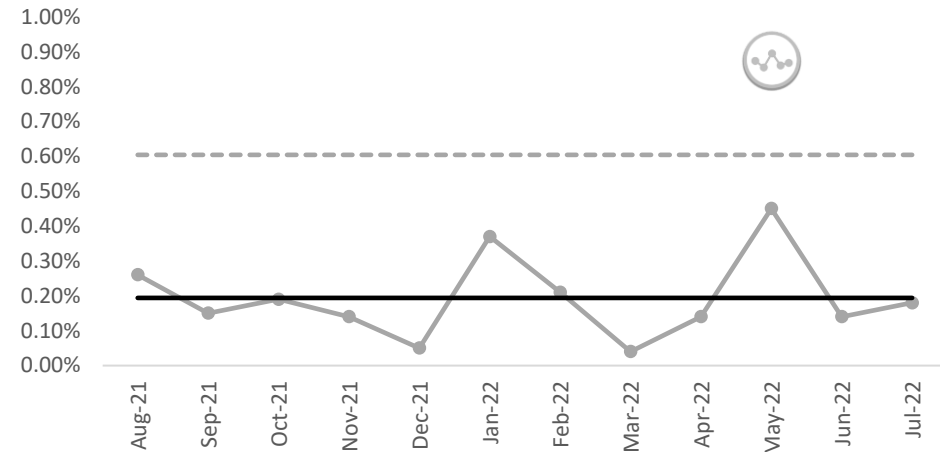
% of patient safety incidents graded severe/major harm* ICHT



% of patient safety incidents graded severe/major harm* THH

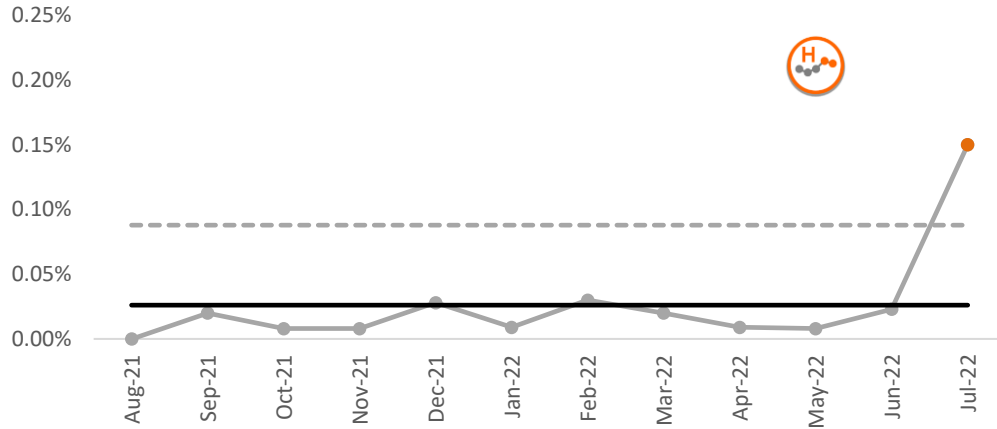


% of patient safety incidents graded severe/major harm* LNW

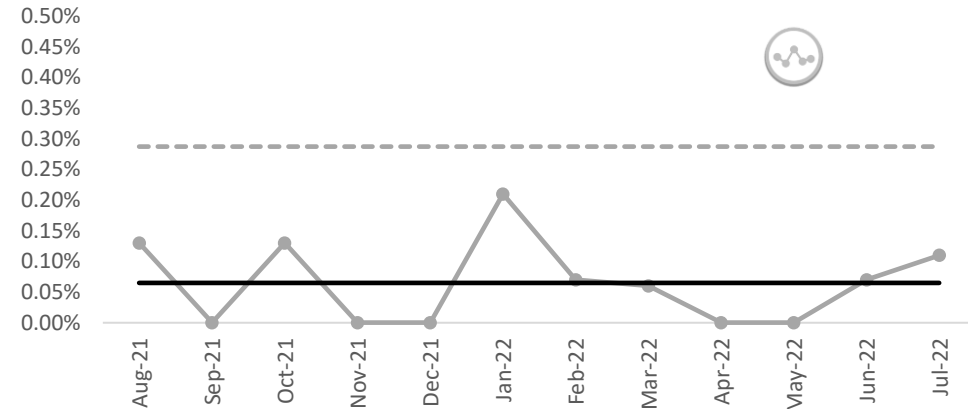


Metric: % of patient safety incidents graded extreme harm/death
CQC Domain: Safe
Month: July 2022
Target:

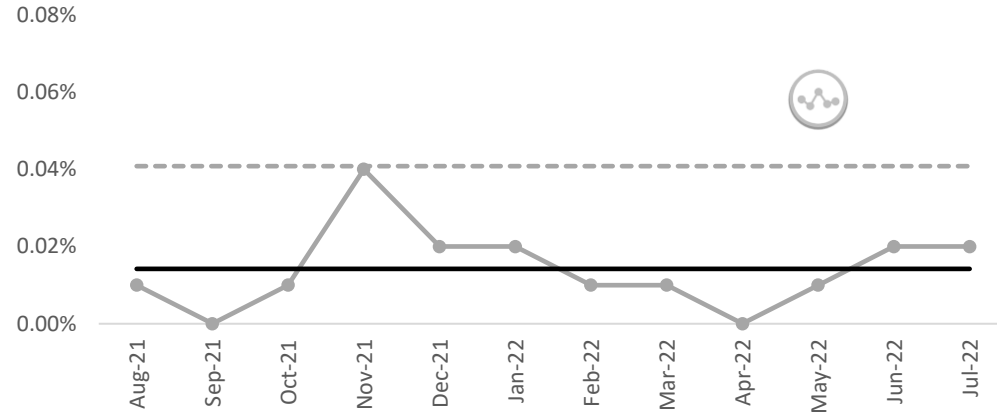
% of patient safety incidents graded extreme harm/death* CW



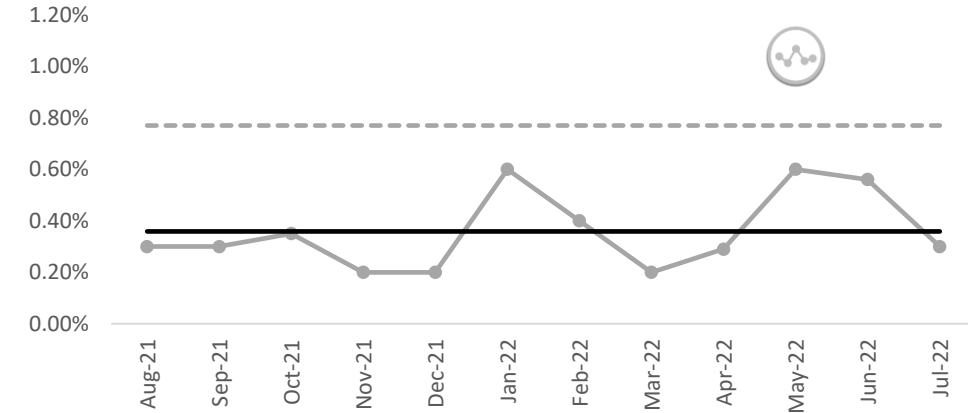
% of patient safety incidents graded extreme harm/death* ICHT



% of patient safety incidents graded extreme harm/death* THH

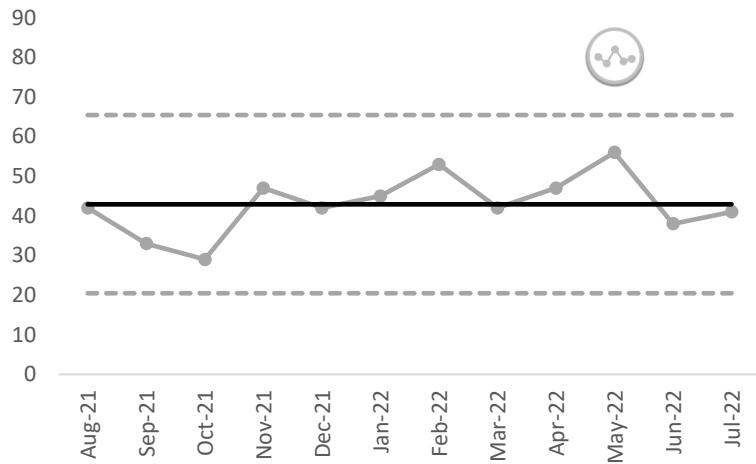


% of patient safety incidents graded extreme harm/death* LNw

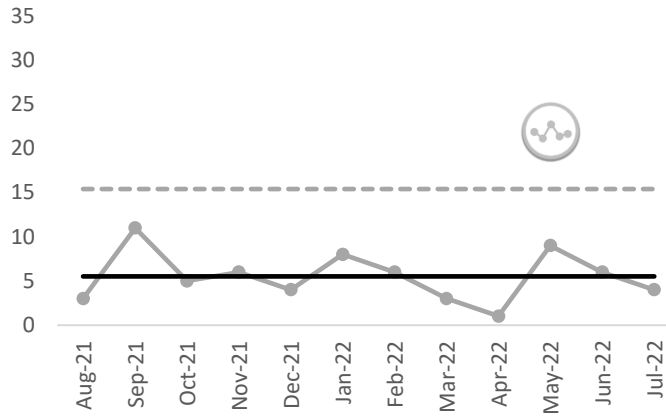


Metric: Number SI declared
CQC Domain: Safe
Month: July 2022
Target:

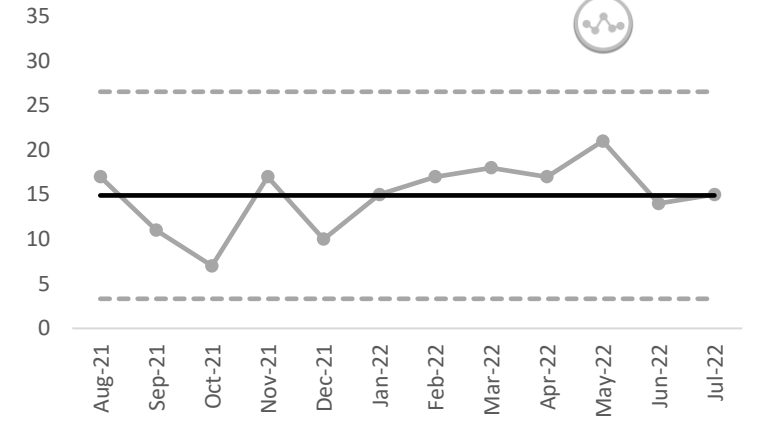
Number SI declared Sector



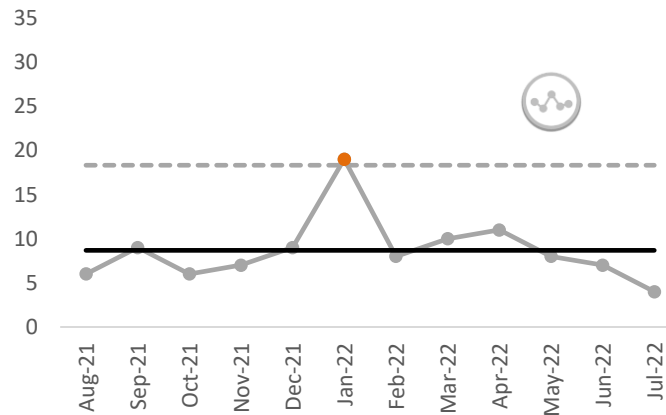
Number SI declared CW



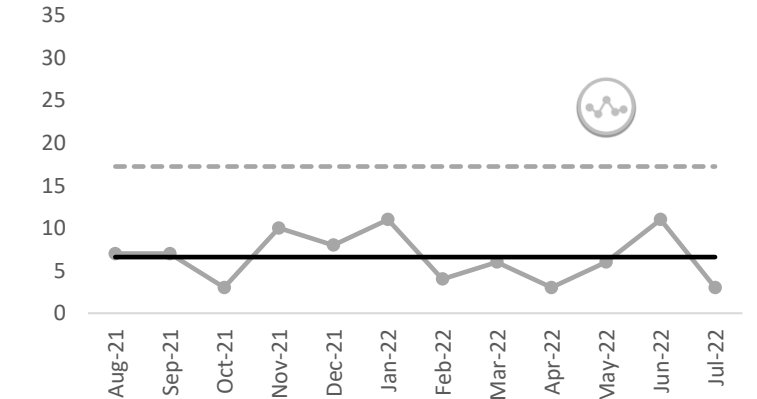
Number SI declared ICHT



Number SI declared THH

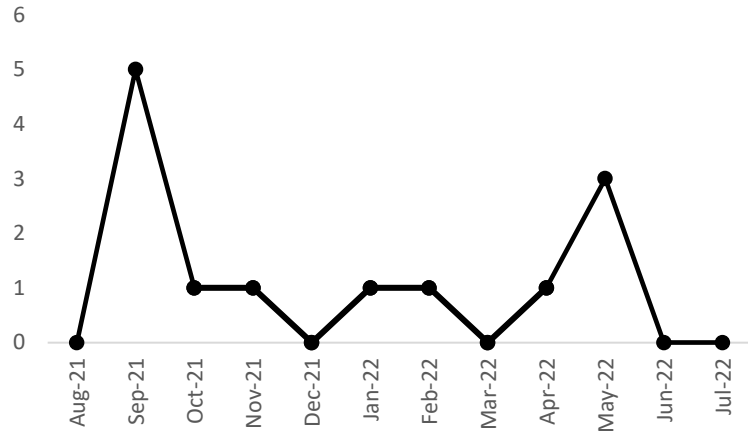


Number SI declared LNW

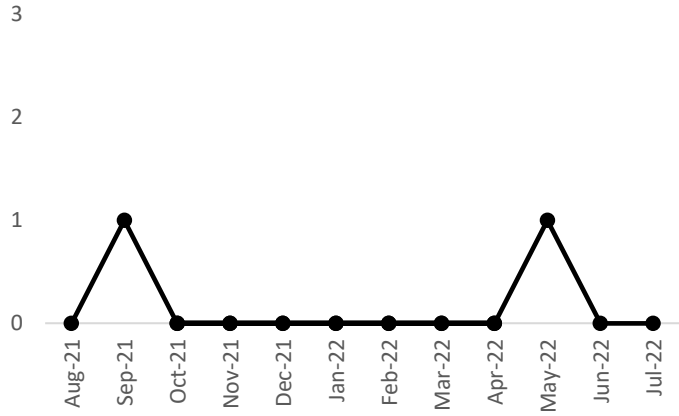


Metric: Never Events
CQC Domain: Safe
Month: July 2022
Target:

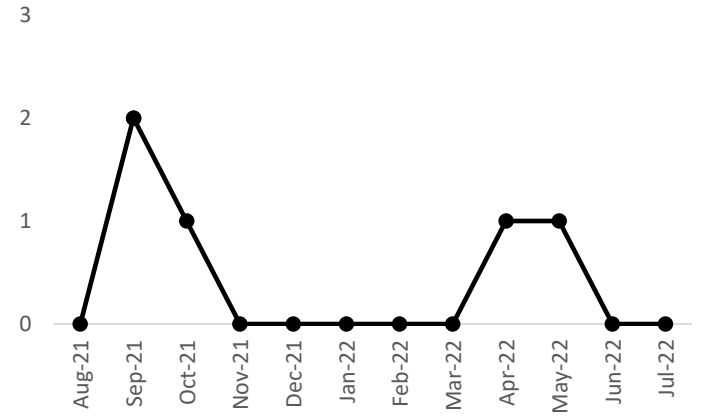
Never Events Sector



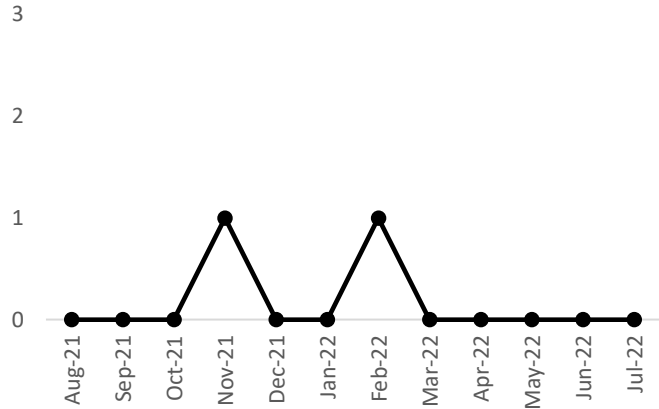
Never Events CW



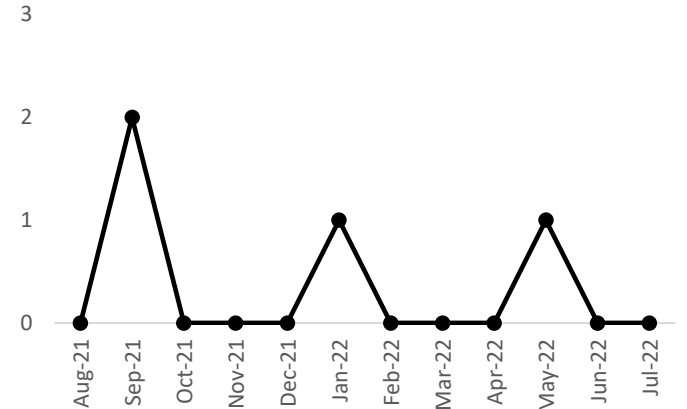
Never Events ICHT



Never Events THH

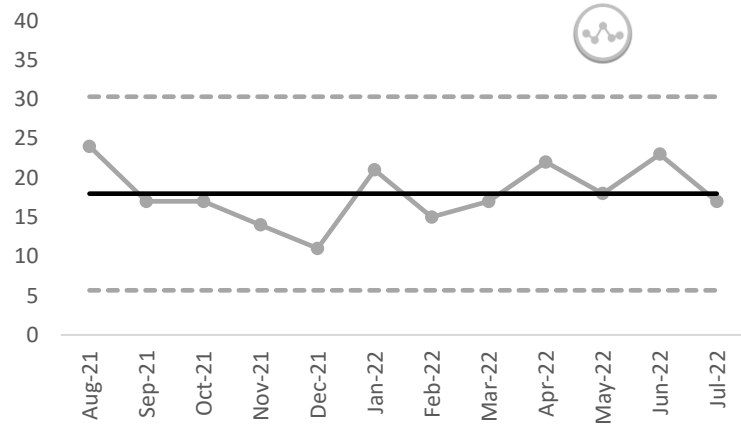


Never Events LNW

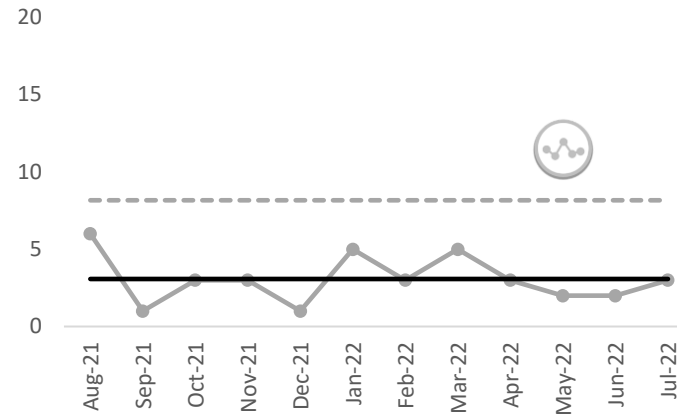


Metric: C.Diff (Combined position)
CQC Domain: Safe
Month: July 2022
Target:

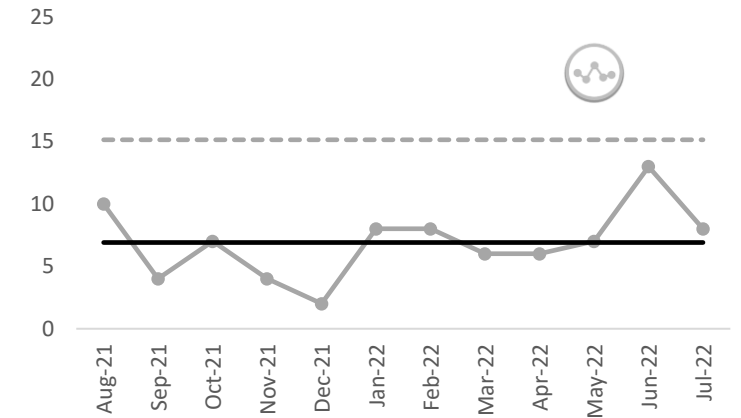
C.Diff (Combined position) - Sector



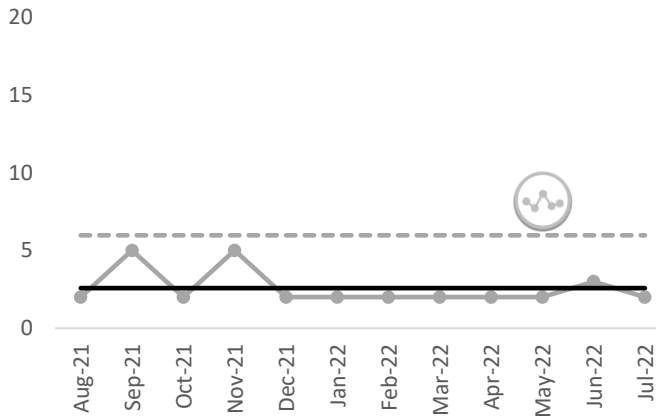
C.Diff (Combined position) - CWH



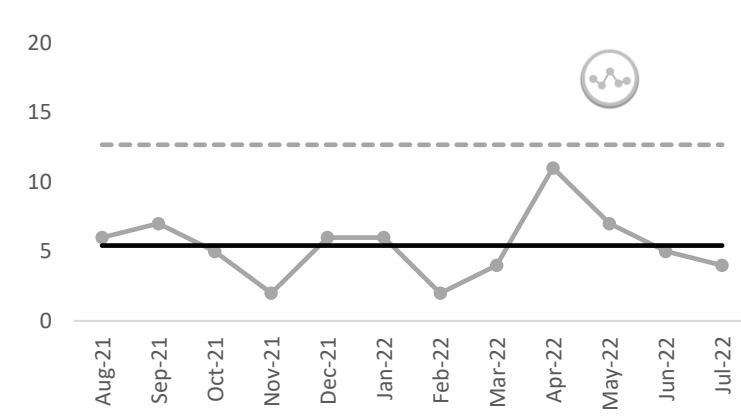
C.Diff (Combined position) - ICH



C.Diff (Combined position) - THH

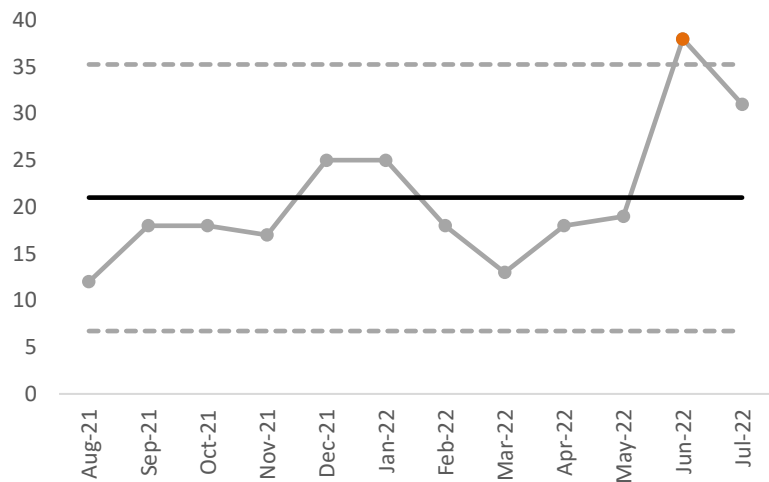


C.Diff (Combined position) - LNW

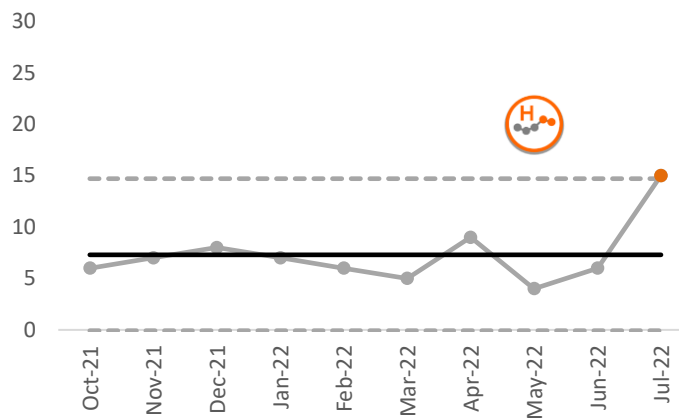


Metric: E.Coli blood stream infection
CQC Domain: Safe
Month: July 2022
Target:

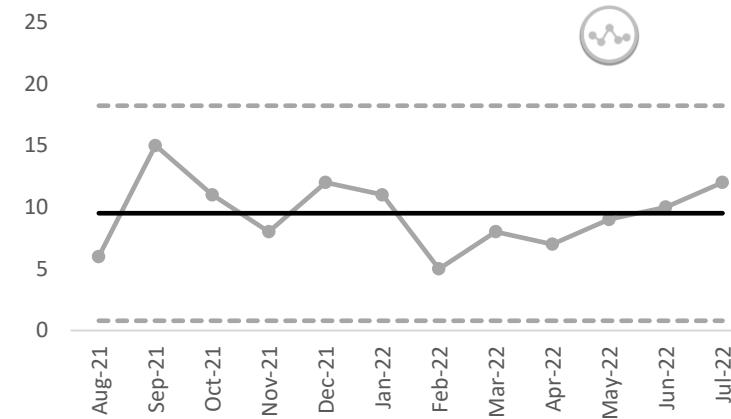
E.coli blood stream infection - Sector



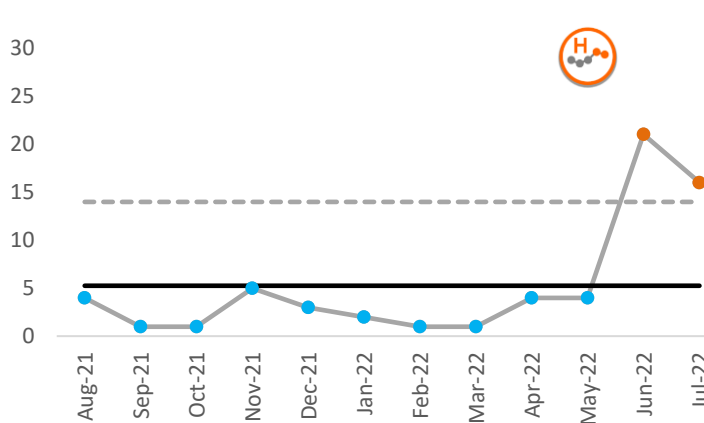
E.coli blood stream infection - CWH



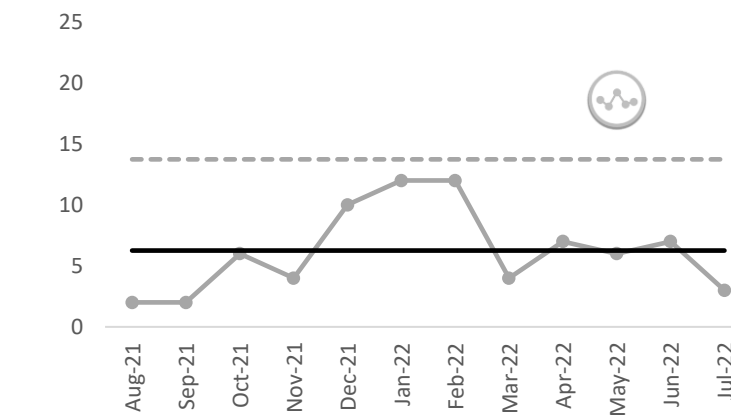
E.coli blood stream infection - ICH



E.coli blood stream infection - THH

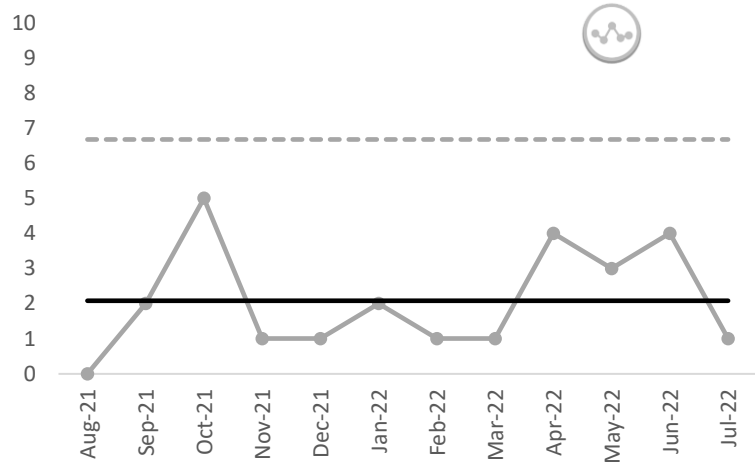


E.coli blood stream infection - LNW

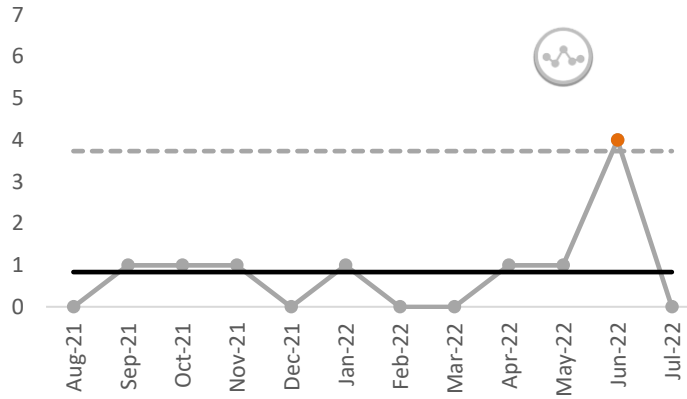


Metric: MRSA Bacteraemia (Trust)
CQC Domain: Safe
Month: July 2022
Target:

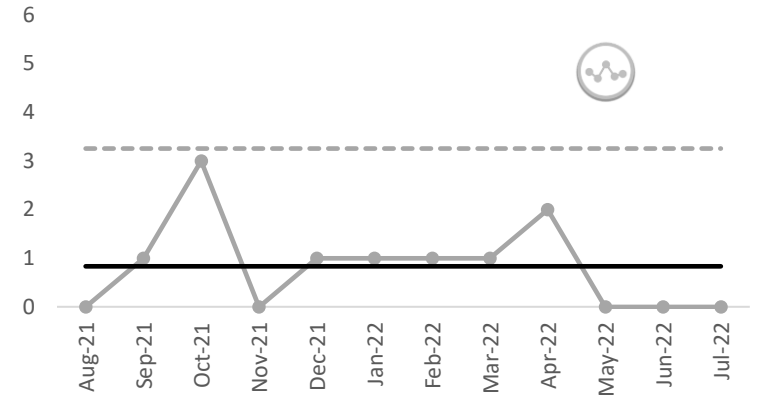
MRSA Bacteraemia (Trust) - Sector



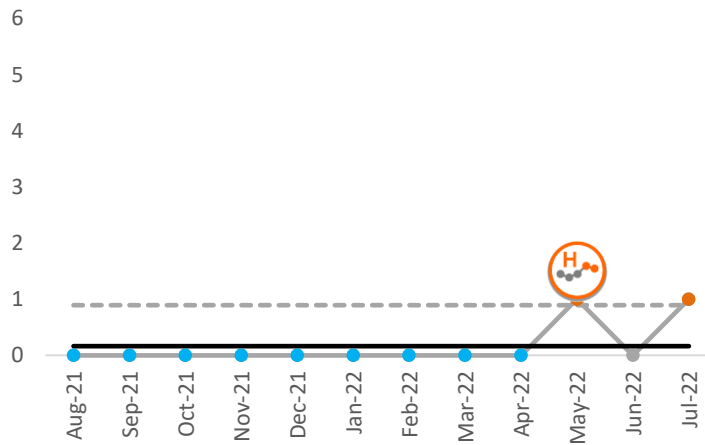
MRSA Bacteraemia (Trust) - CWH



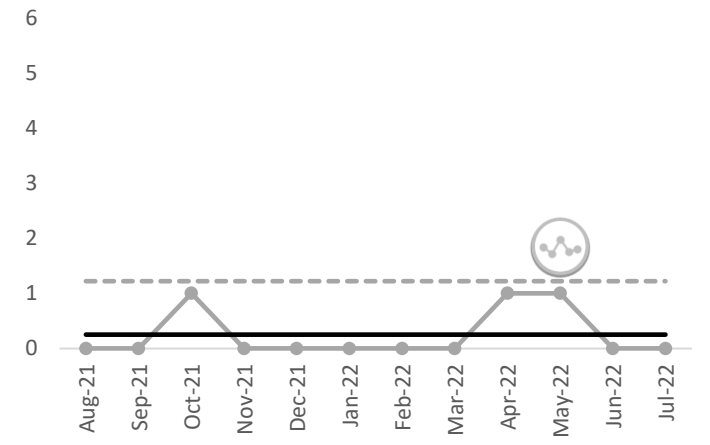
MRSA Bacteraemia (Trust) - ICH



MRSA Bacteraemia (Trust) - THH

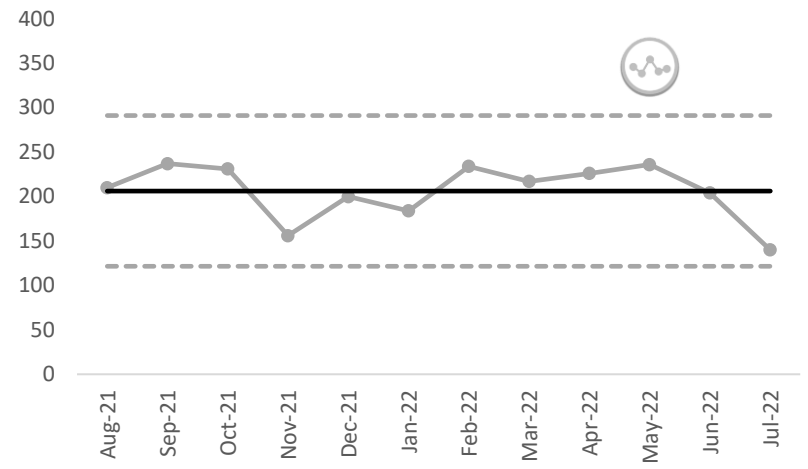


MRSA Bacteraemia (Trust) - LNW

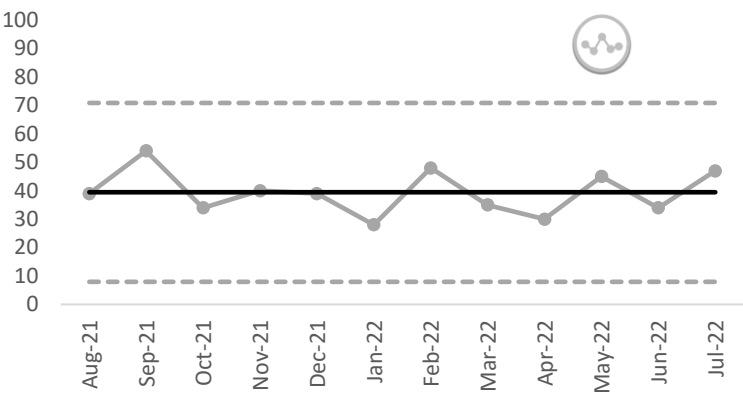


Metric: Count of formal complaints received
CQC Domain: Responsive
Month: July 2022
Target:

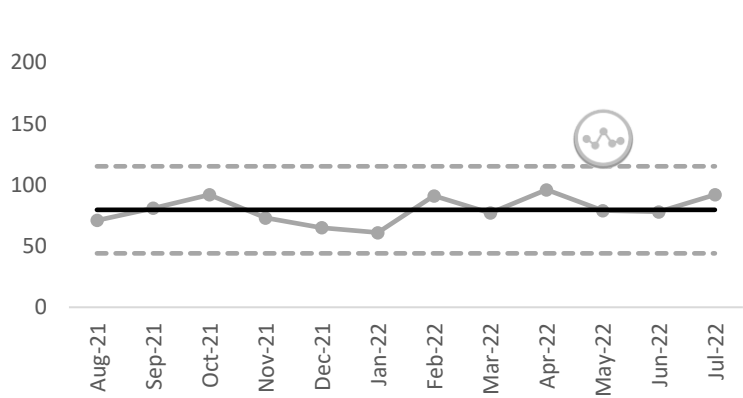
Count of formal complaints rec'd - Sector



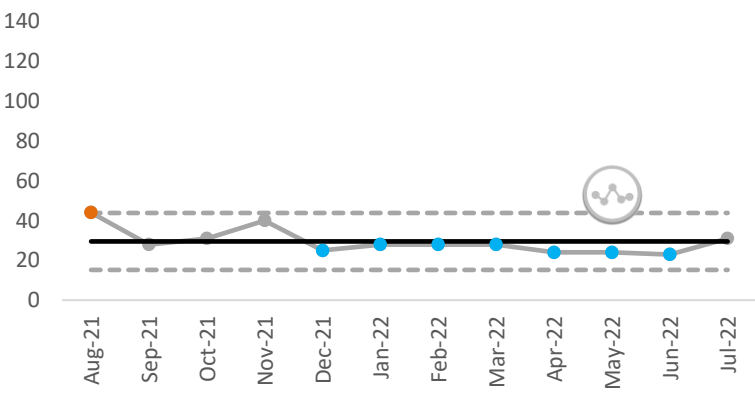
Count of formal complaints rec'd - CWH



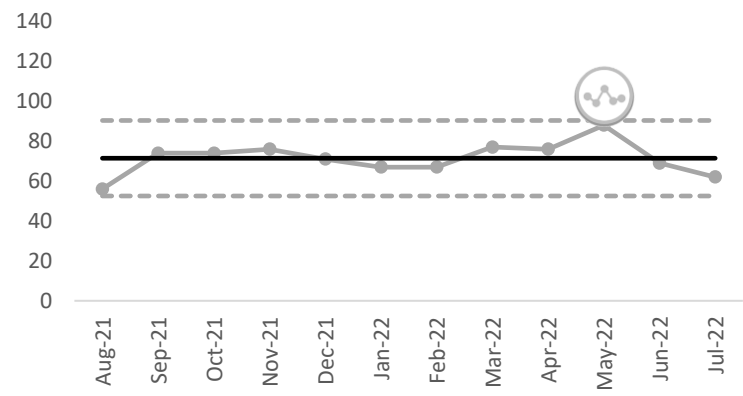
Count of formal complaints rec'd - ICH



Count of formal complaints rec'd - THH

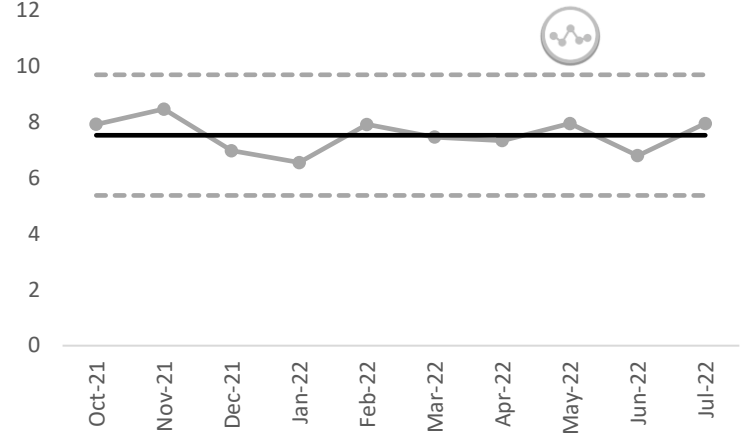


Count of formal complaints rec'd - LNW

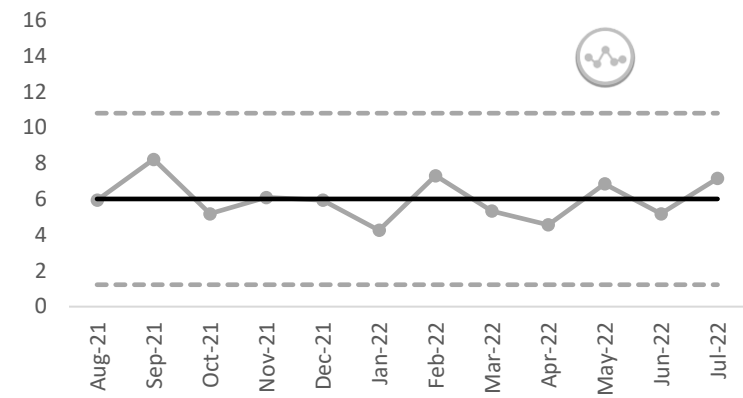


Metric: Count of formal complaints rec'd per 1000 staff (WTES)
CQC Domain: Responsive
Month: July 2022
Target:

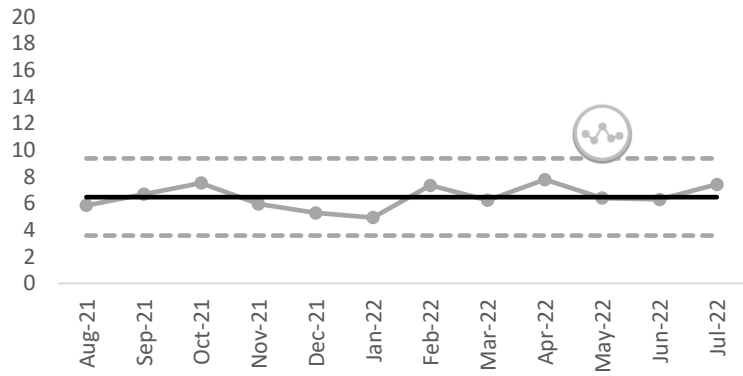
Count of formal complaints rec'd per 1000 staff (WTES) - Sector



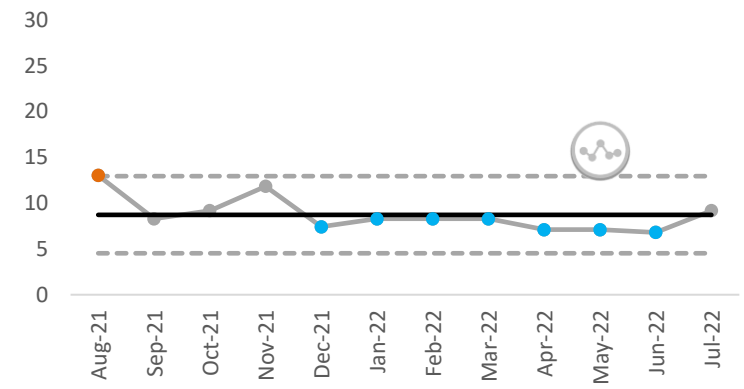
Count of formal complaints rec'd per 1000 staff (WTES) - CWH



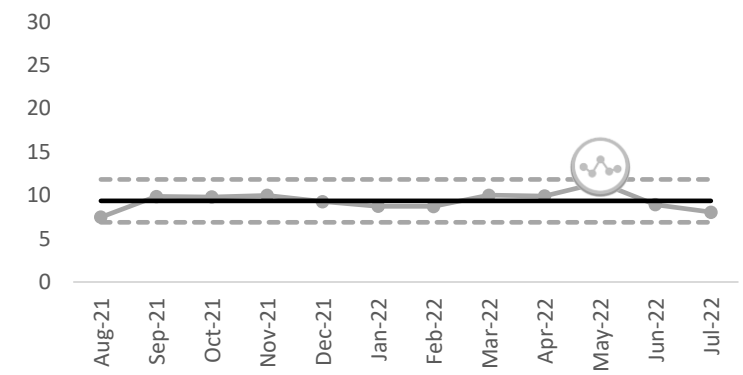
Count of formal complaints rec'd per 1000 staff (WTES) - ICH



Count of formal complaints rec'd per 1000 staff (WTES) - THH

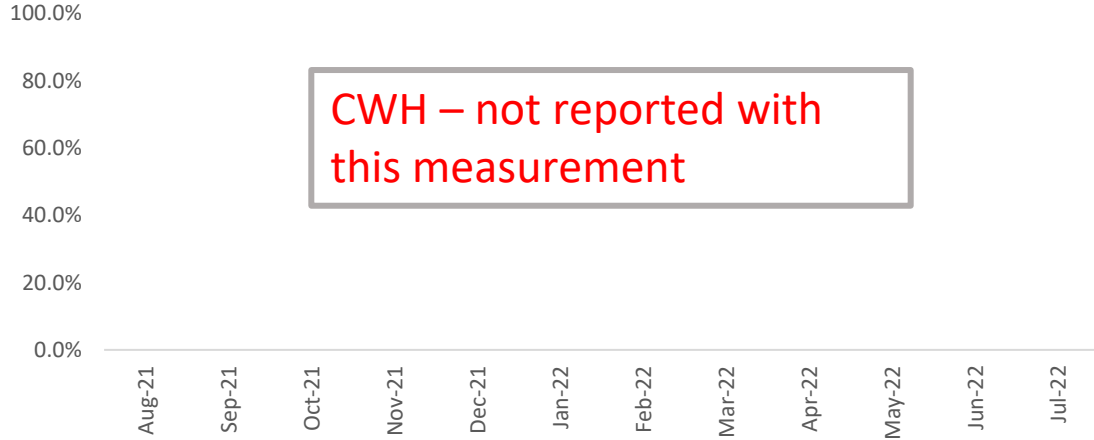


Count of formal complaints rec'd per 1000 staff (WTES) - LNW

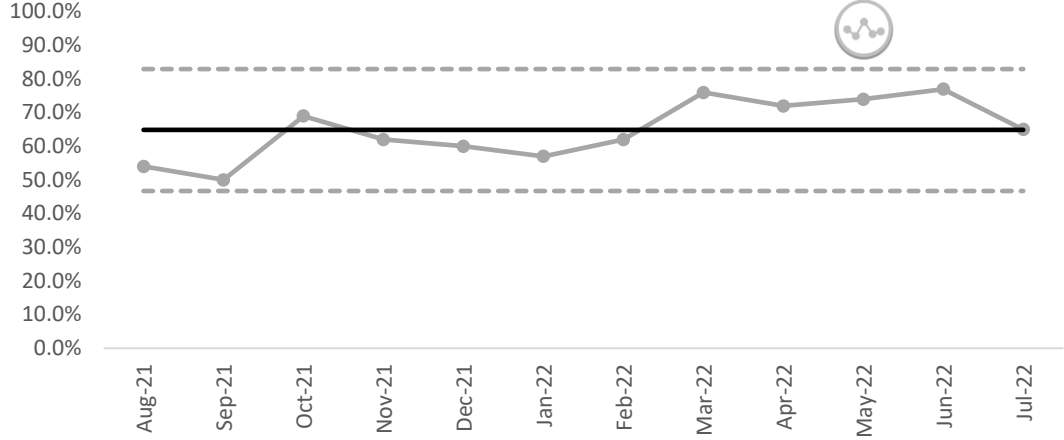


Metric: Complaints response performance
CQC Domain: Responsive
Month: July 2022
Target:

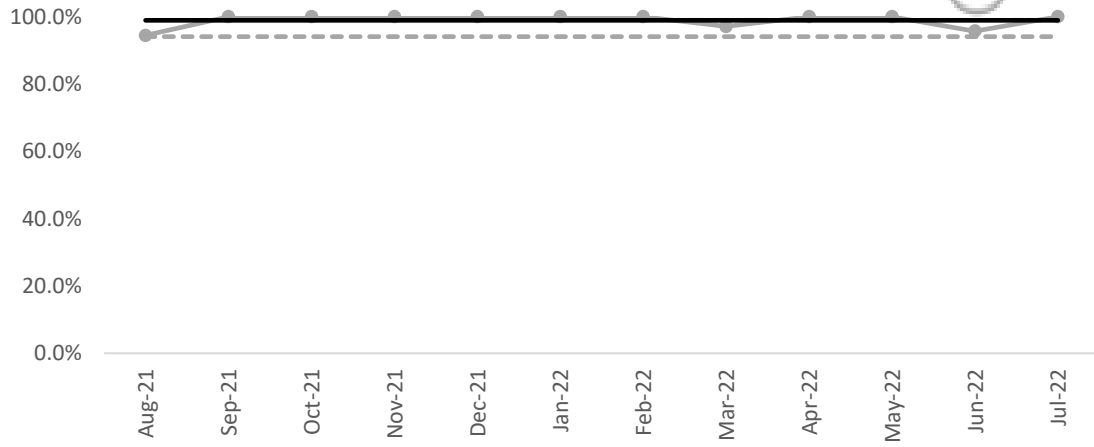
Complaints response performance - CWH



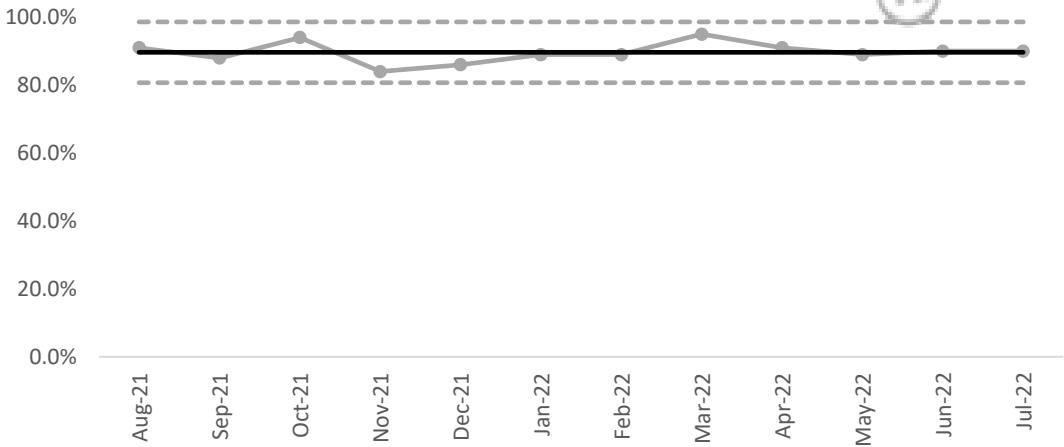
Complaints response performance - ICH



Complaints response performance - THH

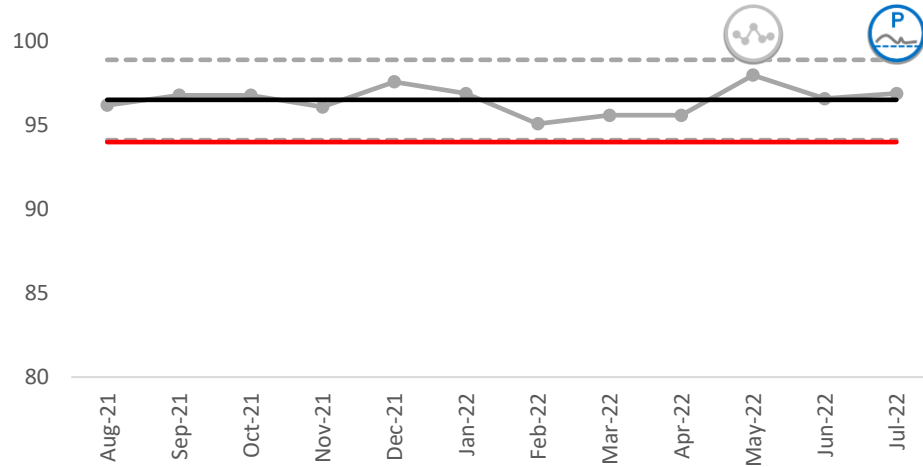


Complaints response performance - LNW

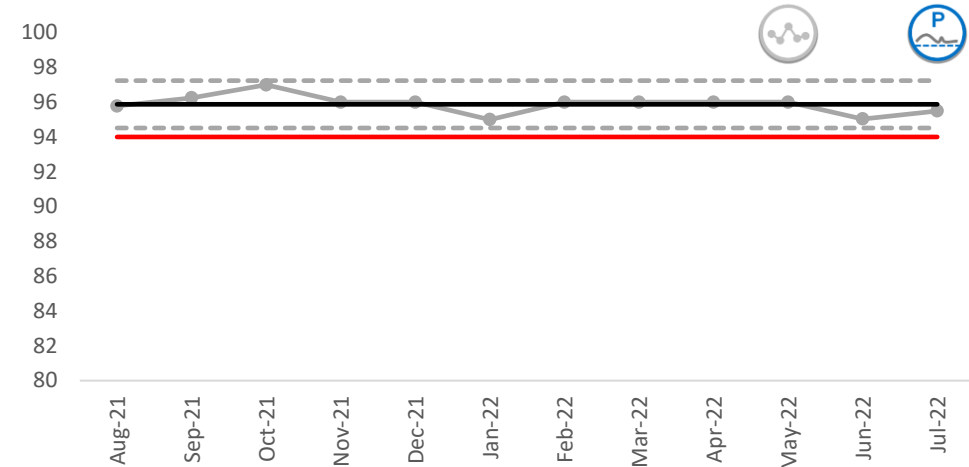


Metric: % good experience Trust inpatient
CQC Domain: Caring
Month: July 2022
Target:

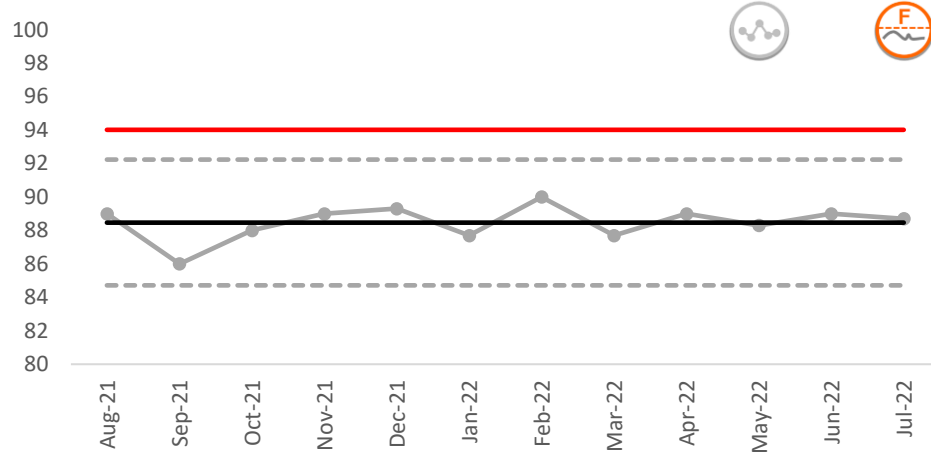
% good experience Trust inpatient - CWH



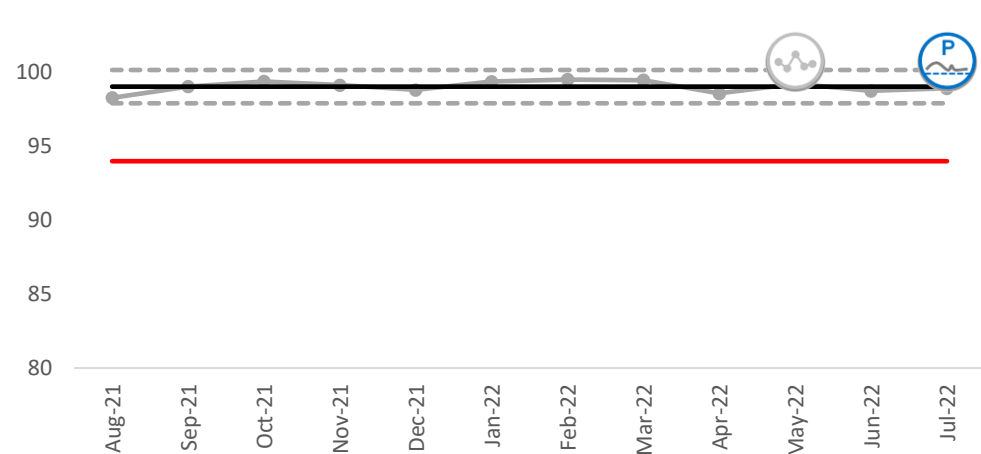
% good experience Trust inpatient - ICH



% good experience Trust inpatient - THH

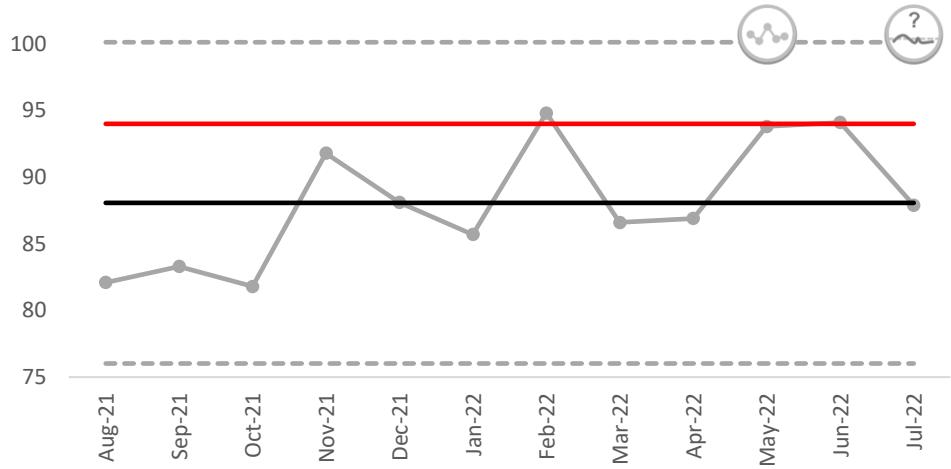


% good experience Trust inpatient - LNWH

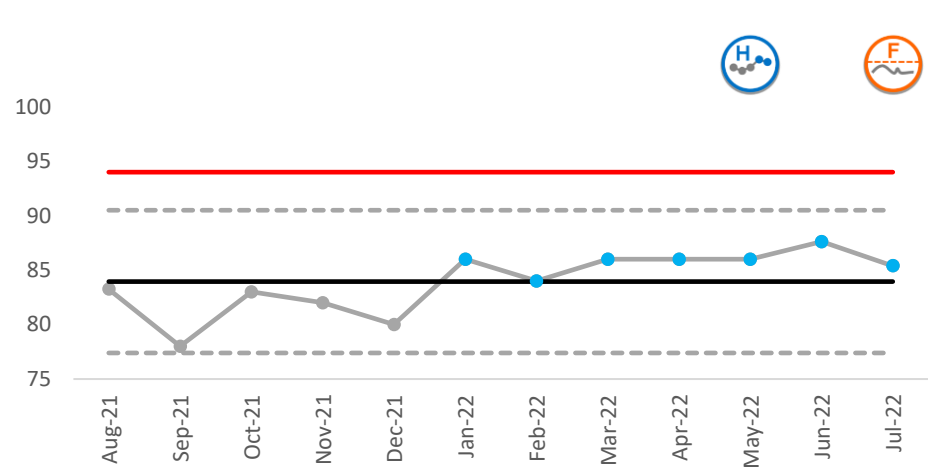


Metric: % good experience maternity
CQC Domain: Caring
Month: July 2022
Target:

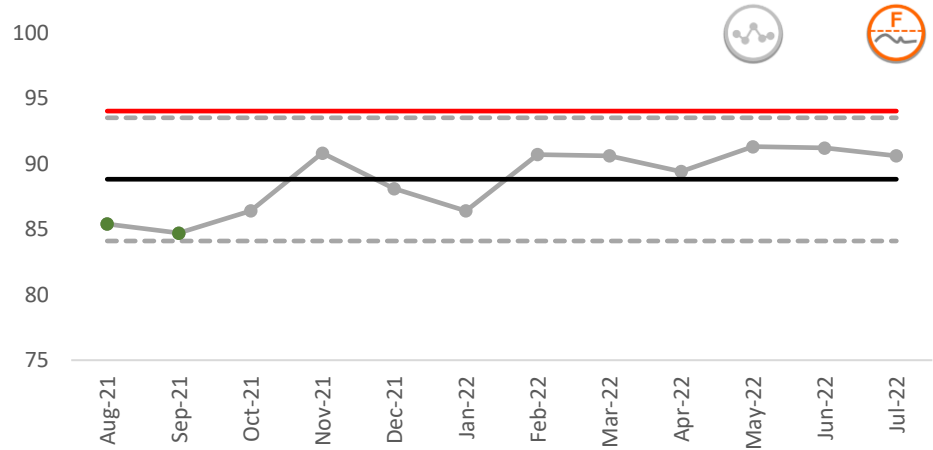
% good experience maternity - CWH



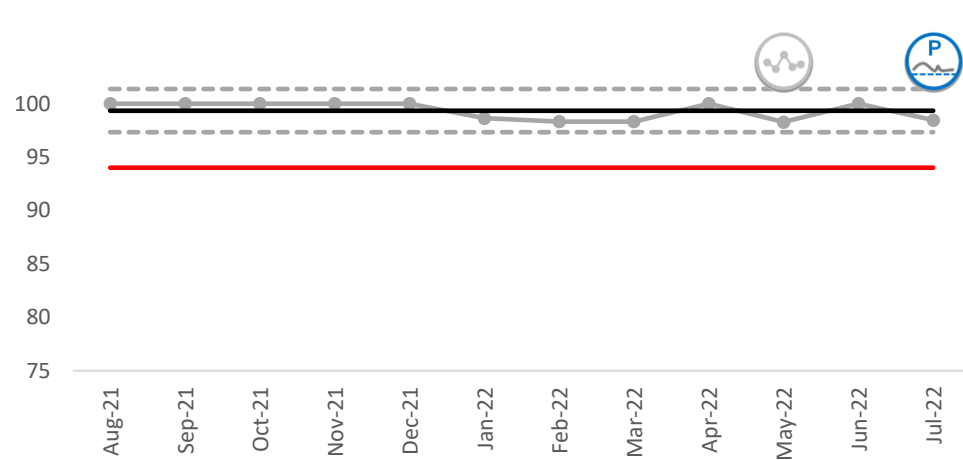
% good experience maternity - ICH



% good experience maternity - THH

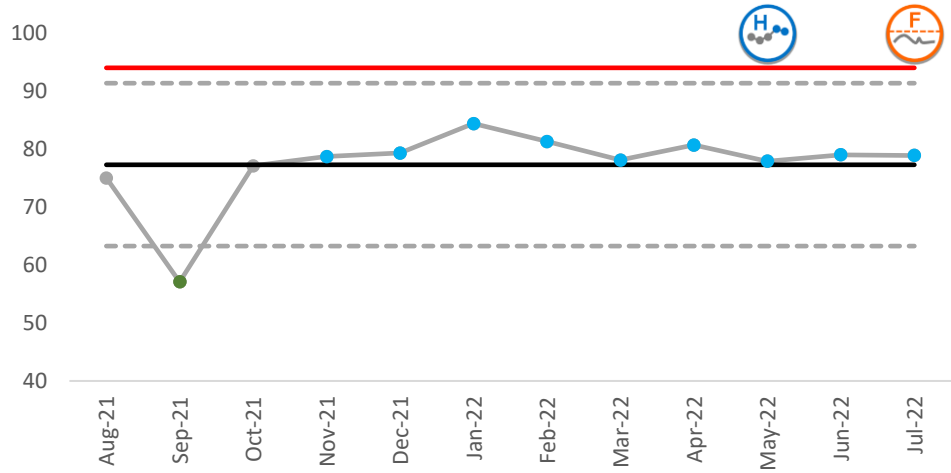


% good experience maternity - LNWH

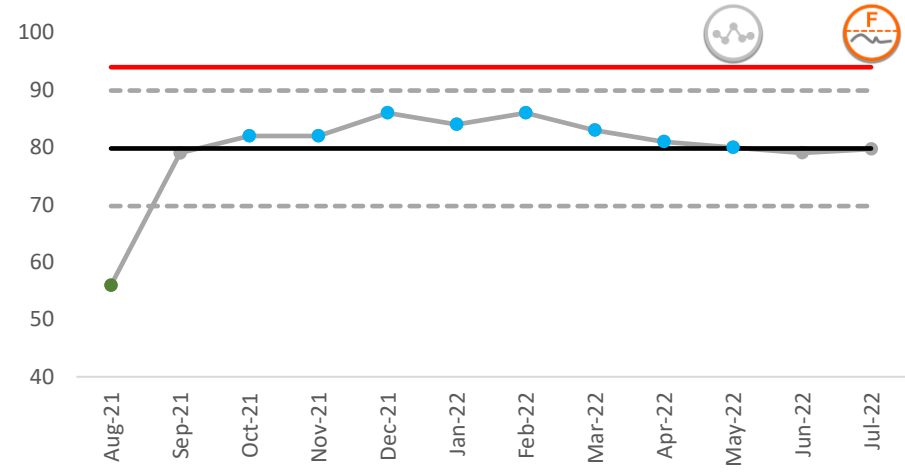


Metric: % good experience ED
CQC Domain: Caring
Month: July 2022
Target:

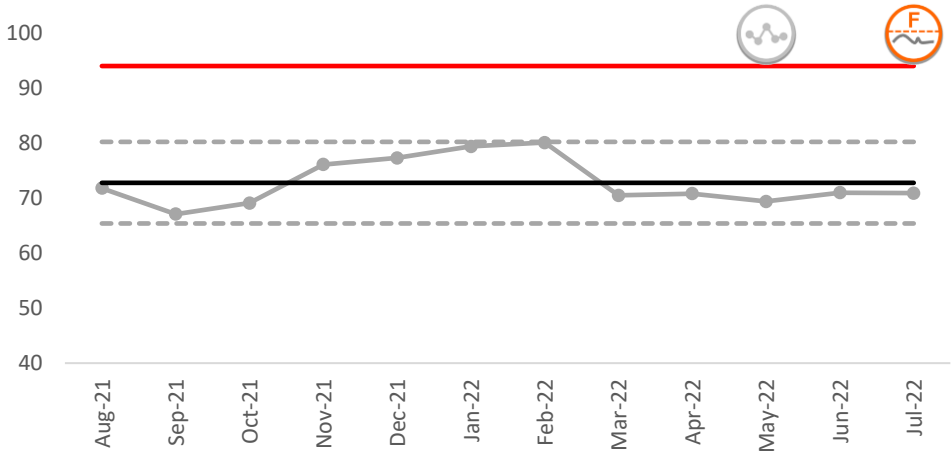
% good experience ED - CWH



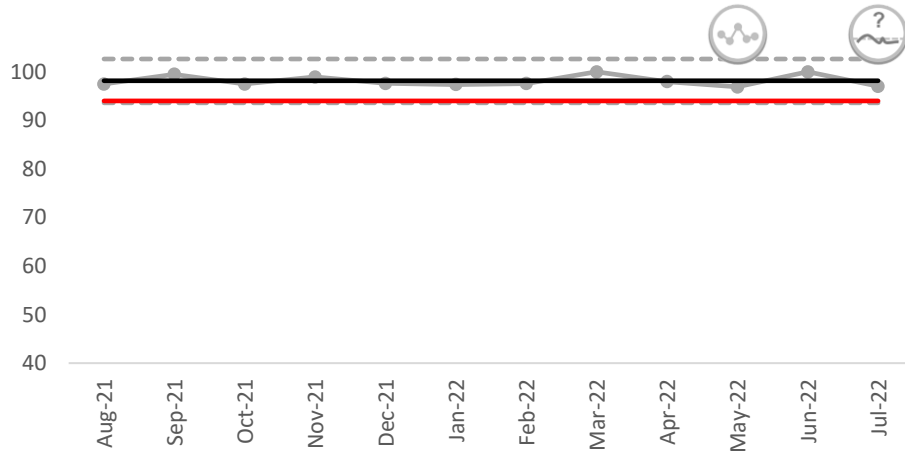
% good experience ED - ICH



% good experience ED - THH

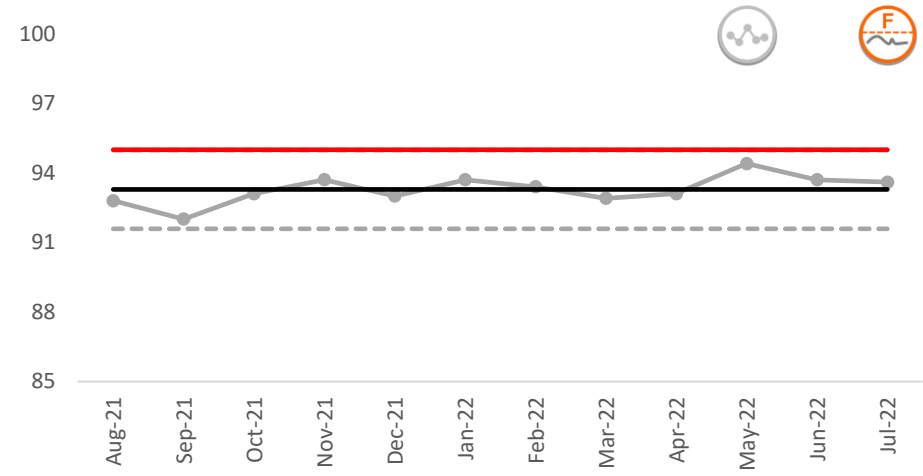


% good experience ED - LNWH

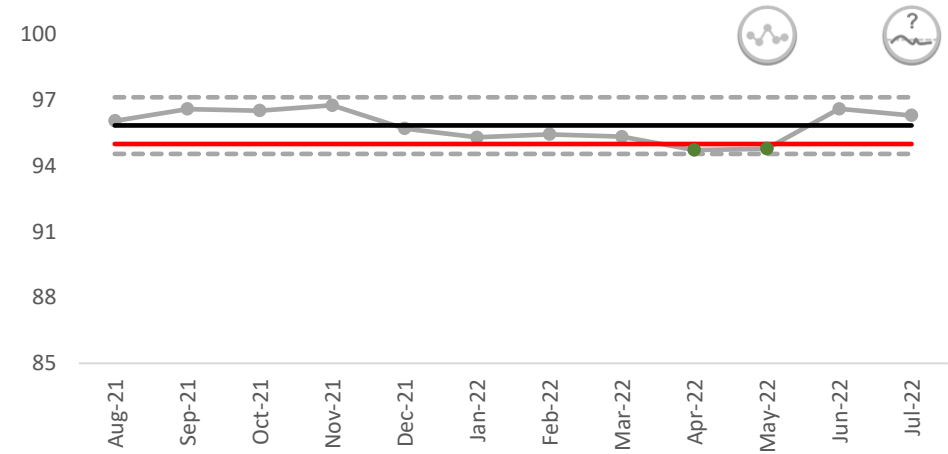


Metric: % VTE risks completed
CQC Domain: Effective
Month: July 2022
Target:

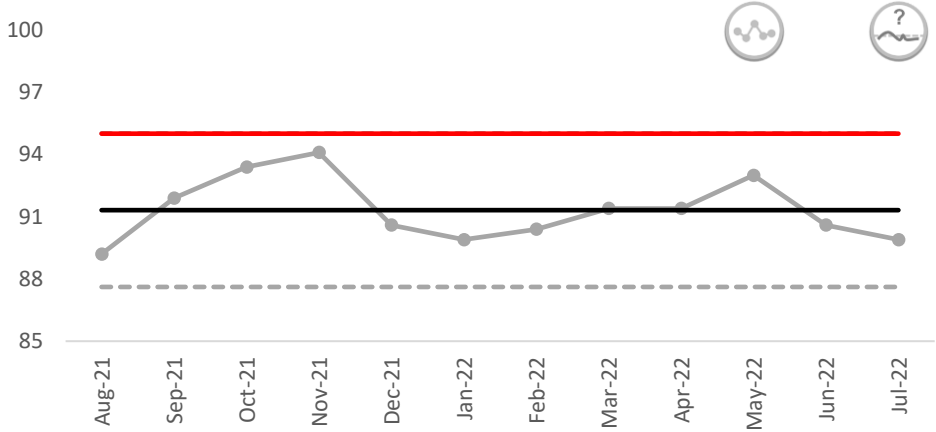
% VTE risks completed - CWH



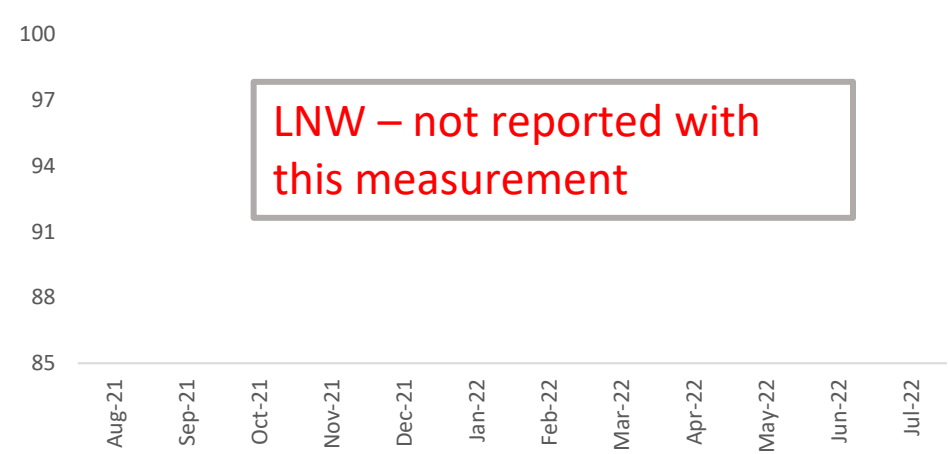
% VTE risks completed - ICH



% VTE risks completed - THH

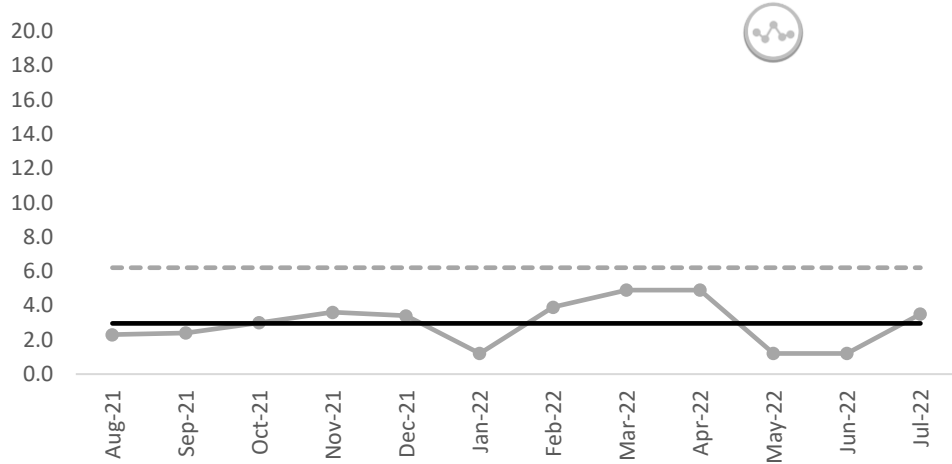


% VTE risks completed - LNW

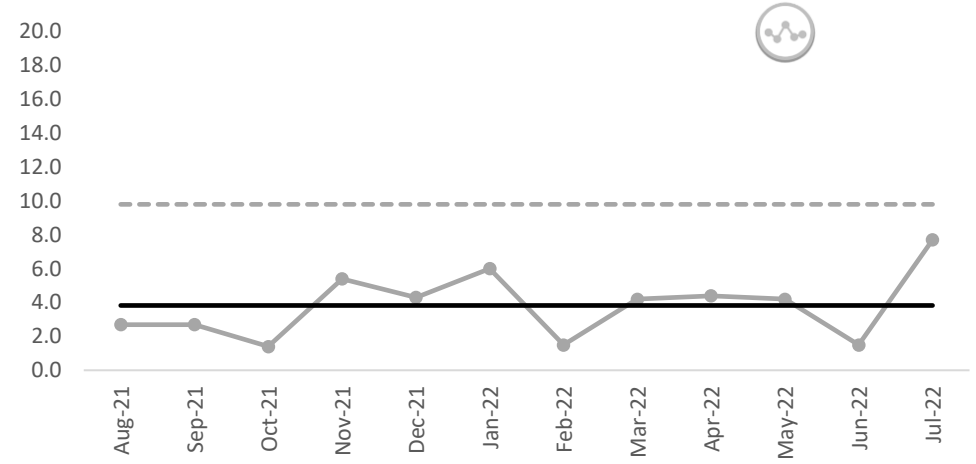


Metric: Crude still birth rate (per 1000 birth rate)
CQC Domain: Effective
Month: July 2022
Target:

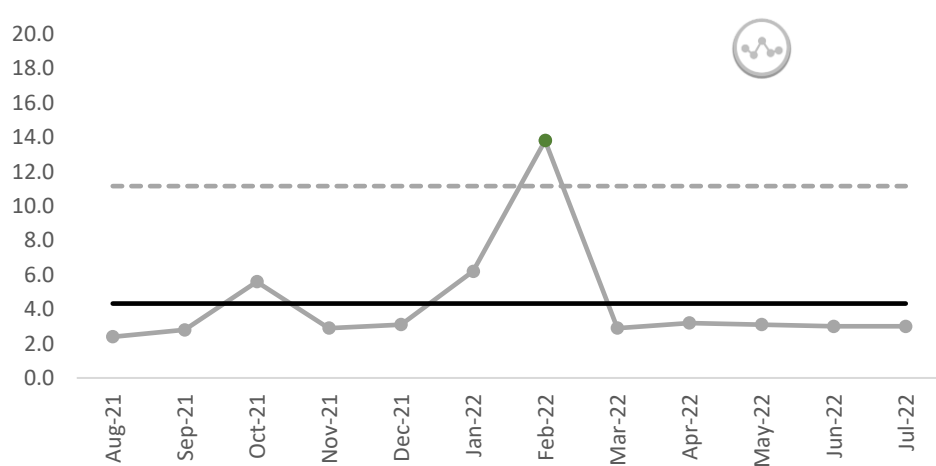
Crude still birth rate (per 1000 birth rate) - CWH



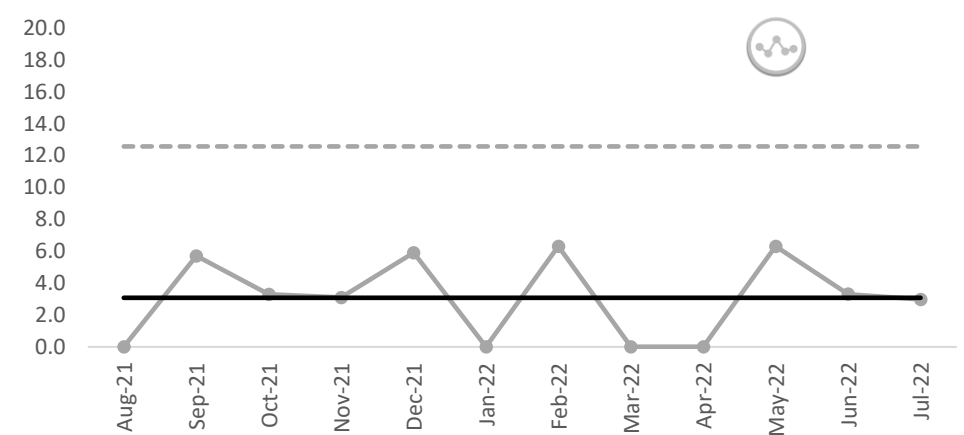
Crude still birth rate (per 1000 birth rate) - ICH



Crude still birth rate (per 1000 birth rate) - THH



Crude still birth rate (per 1000 birth rate) - LNWH



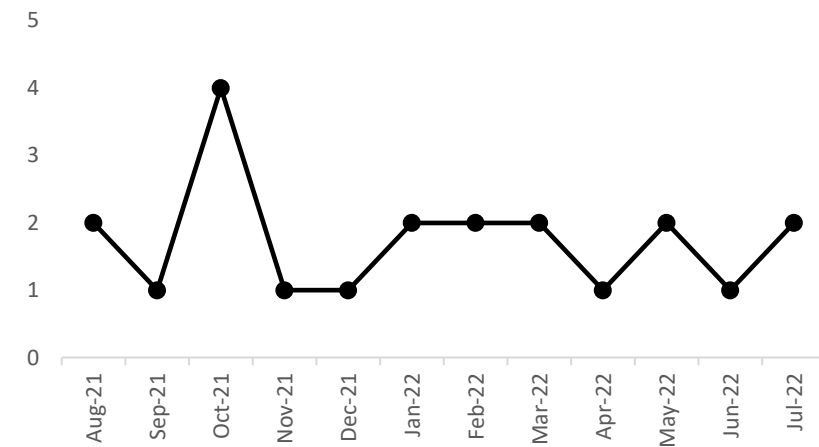
Metric: Number of neonatal intrapartum brain injuries as escalated to HSIB

CQC Domain: Effective

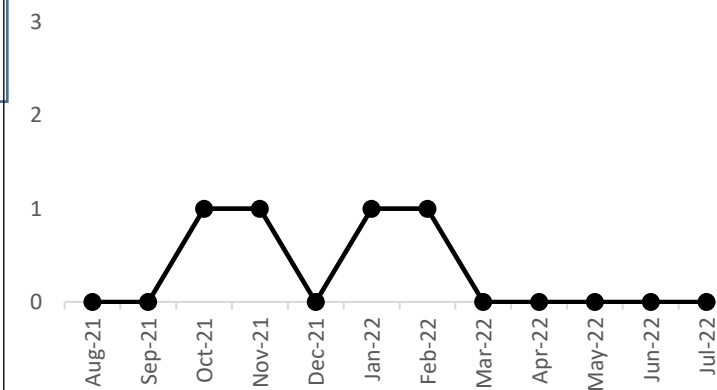
Month: July 2022

Target:

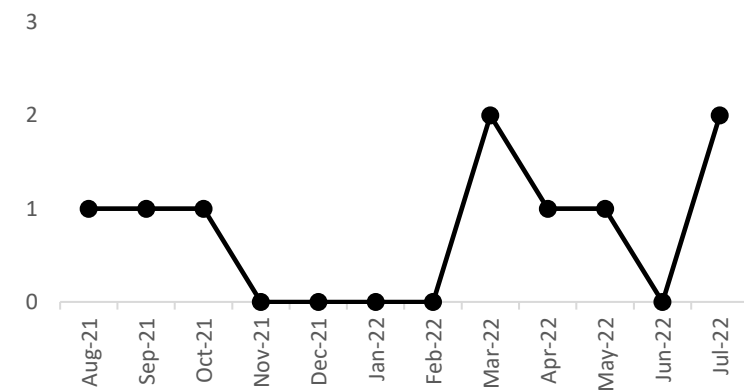
Number of neonatal intrapartum brain injuries as escalated to HSIB - Sector



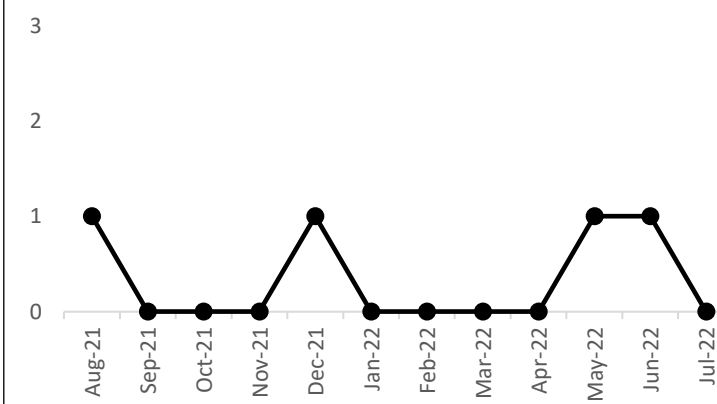
Number of neonatal intrapartum brain injuries as escalated to HSIB - CWH



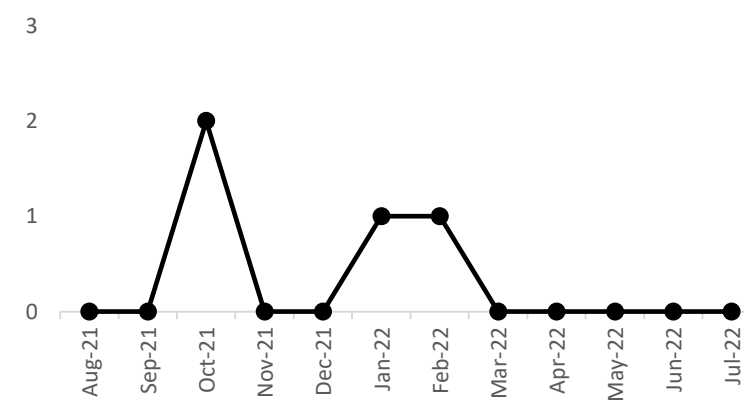
Number of neonatal intrapartum brain injuries as escalated to HSIB - ICH



Number of neonatal intrapartum brain injuries as escalated to HSIB - THH

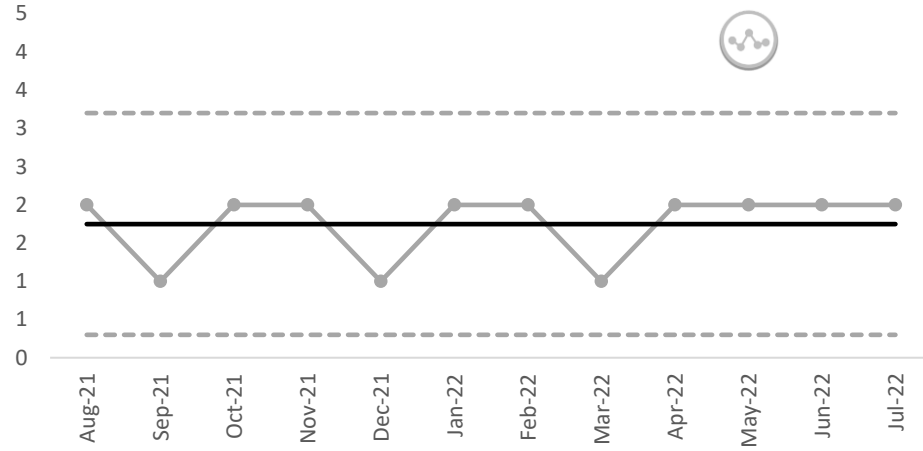


Number of neonatal intrapartum brain injuries as escalated to HSIB - LNWH

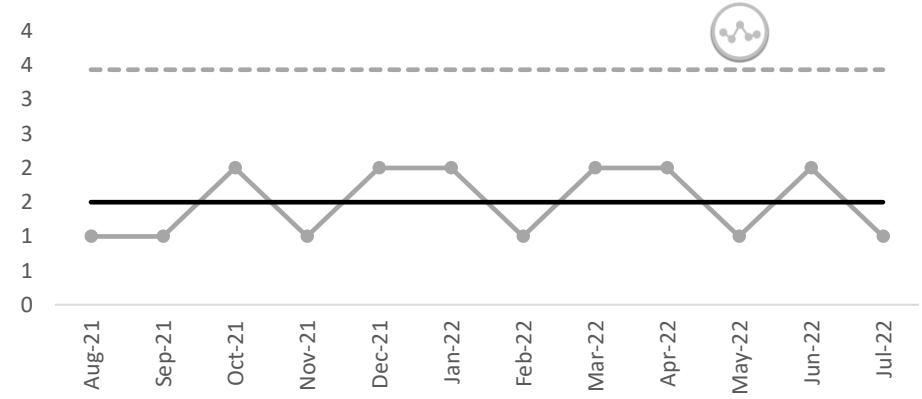


Metric: Avoidable term admissions in Neonates
CQC Domain: Effective
Month: July 2022
Target:

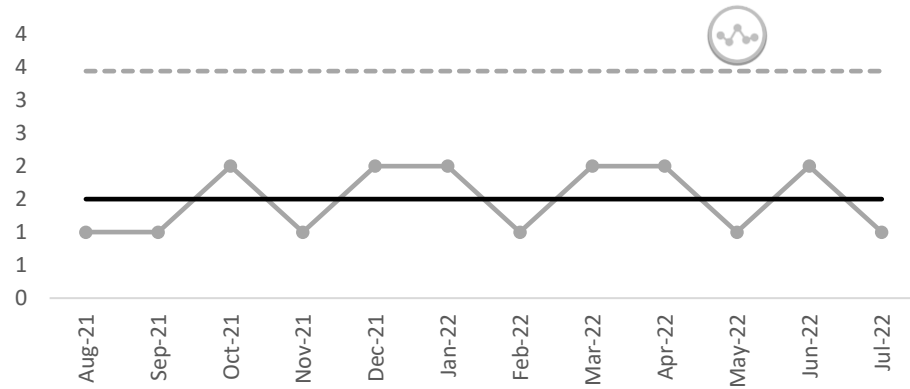
Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more (%) - CWH



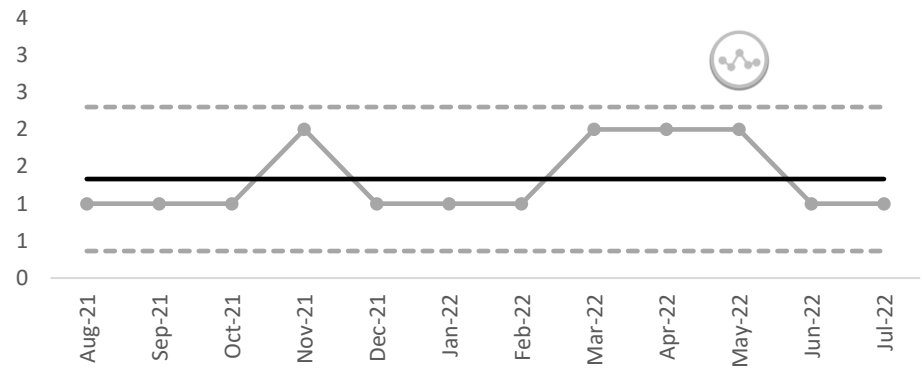
Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more (%) - ICH



Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more (%) - THH



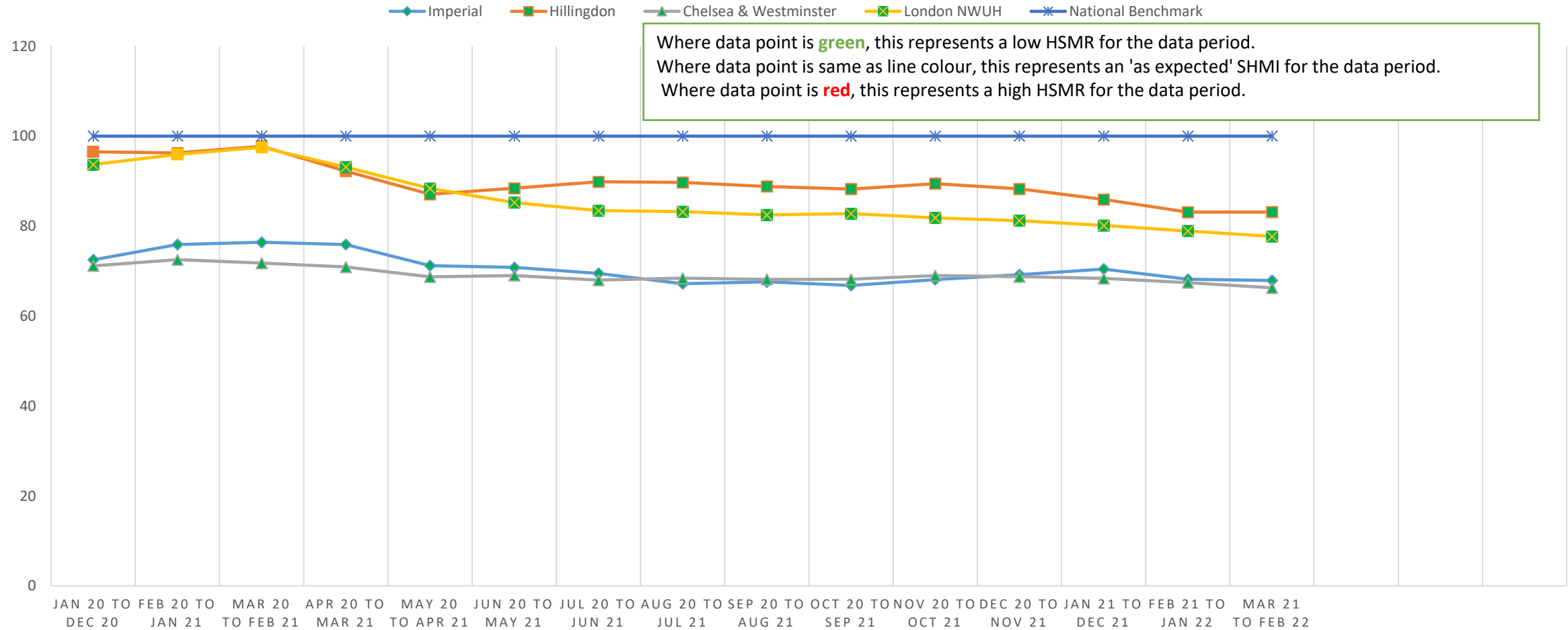
Avoidable Term Admissions in Neonates; proportion of babies >=37 weeks GA admitted to neonatal care for 24 hours or more (%) - LNWH



Metric: HSMR
CQC Domain: Effective
Month: July 2022
Target:

To ensure 'single version of the truth' in data internally at Imperial, rolling 12-month HSMR is as produced for Imperial trust reports. Other providers data is pulled from Telstra Health HIP tool using 20/21 data benchmark.

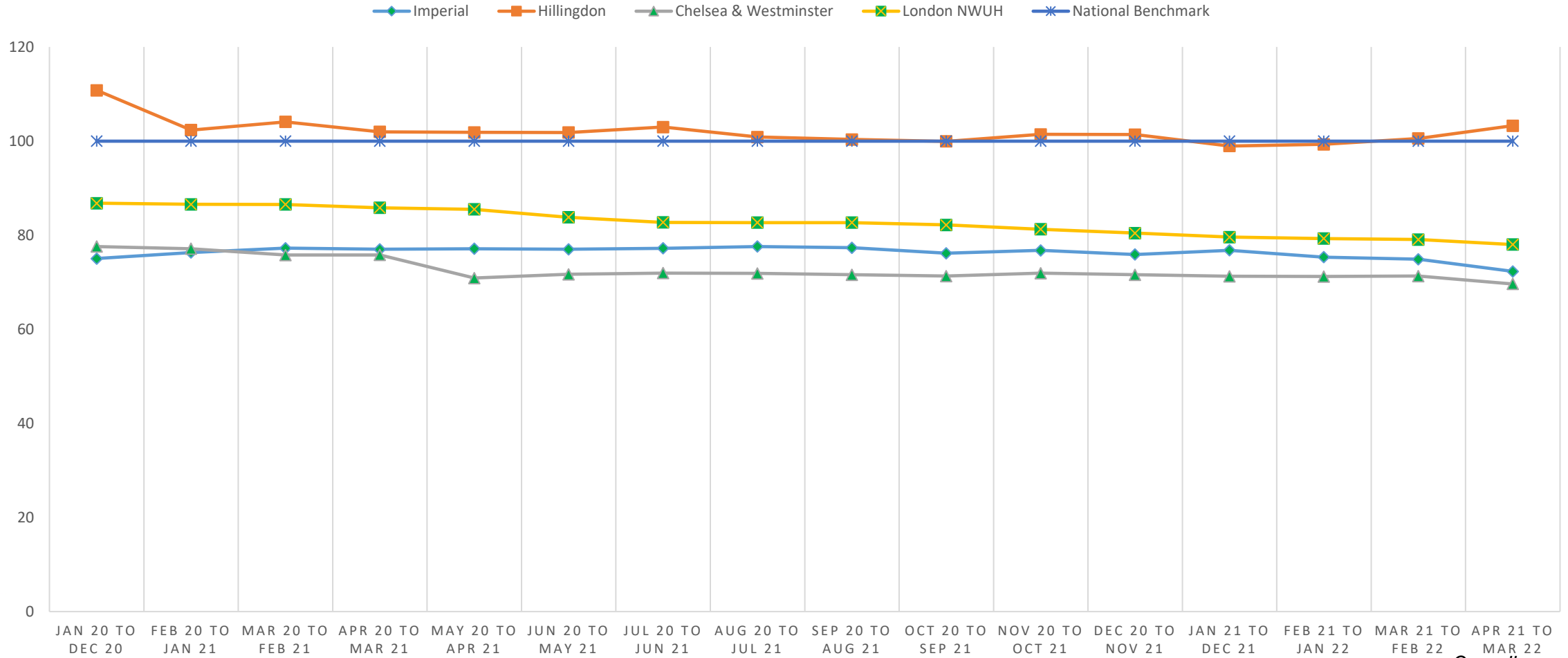
HSMR FIGURES FOR NW LONDON PROVIDERS ROLLING 12 MONTHS



Metric: SHMI
CQC Domain: Effective
Month: July 2022
Target:

To ensure there is a single version of the truth data has been produced as a rolling 12 month position (Trust current reporting may differ)

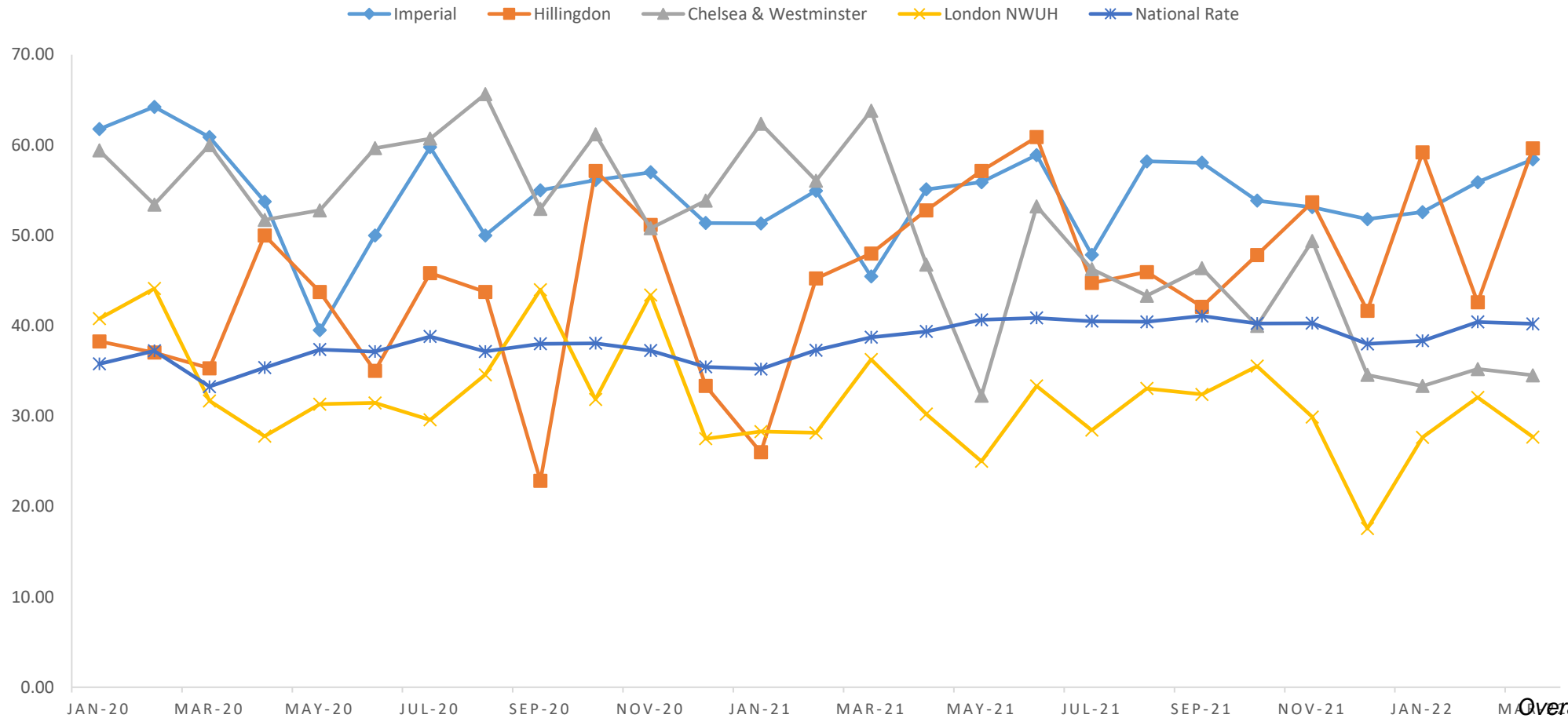
SHMI FIGURES FOR NW LONDON PROVIDERS (ROLLING 12 MONTHS)



Metric: HSMR Palliative Care
CQC Domain: Effective
Month: July 2022
Target:

To ensure there is a single version of the truth data has been produced as a rolling 12 month position (Trust current reporting may differ)

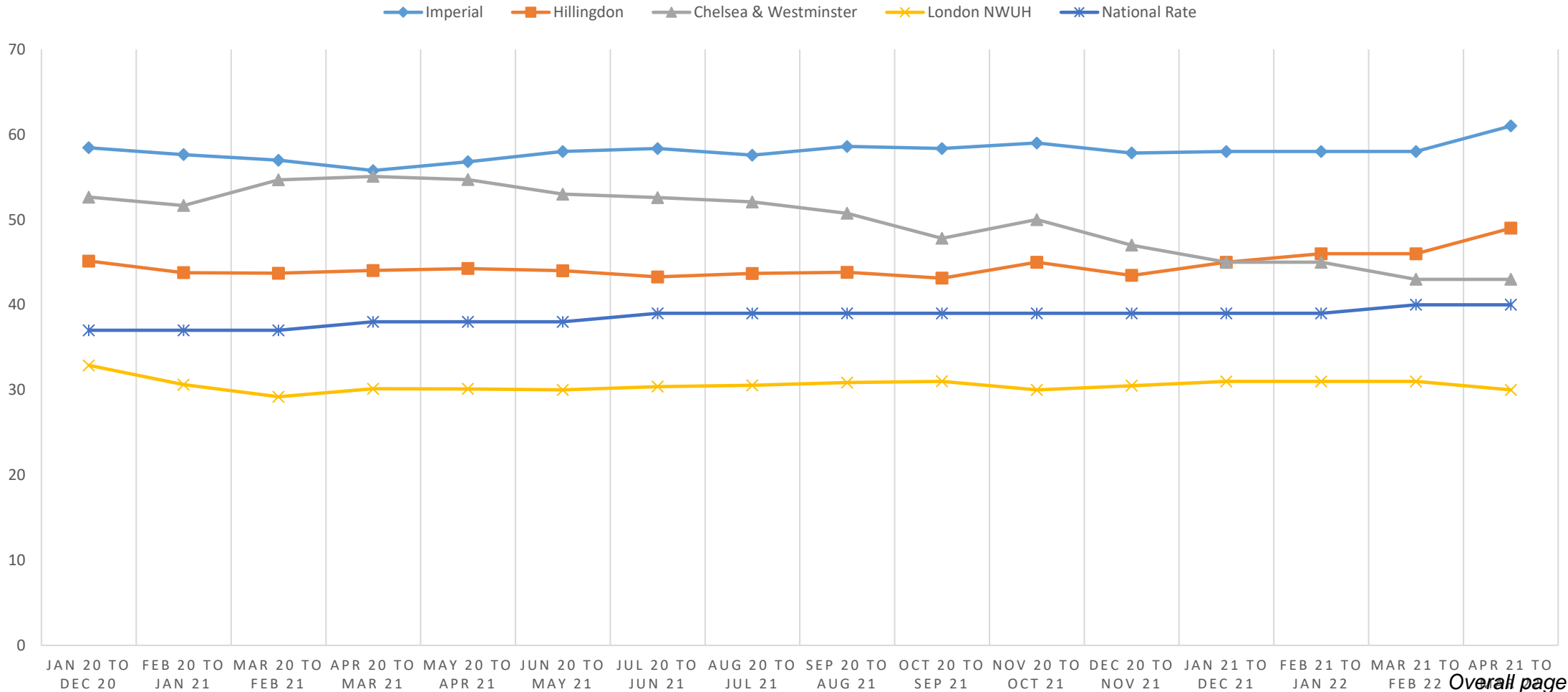
HSMR DEATHS PALLIATIVE CARE CODING RATES (%) FOR NW LONDON PROVIDERS



Metric: SHMI Palliative Care
CQC Domain: Effective
Month: July 2022
Target:

To ensure there is a single version of the truth data has been produced as a rolling 12 month position (Trust current reporting may differ)

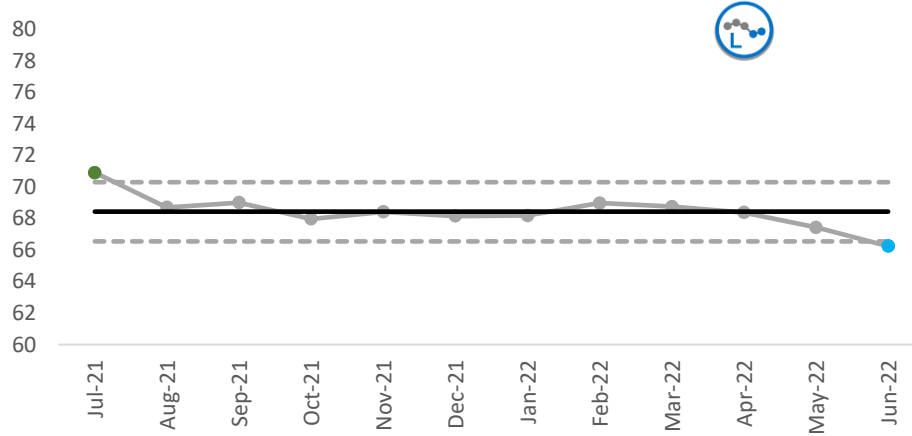
SHMI DEATHS PALLIATIVE CARE CODING RATES (%) BY NW LONDON PROVIDERS



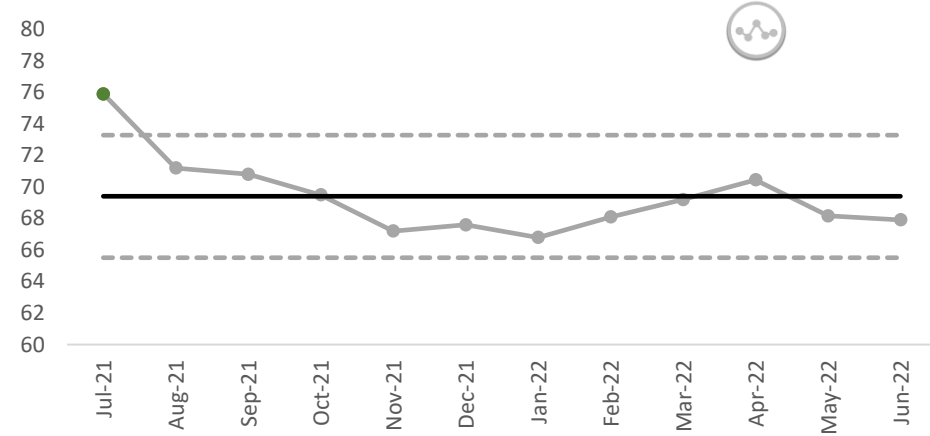
Metric: HSMR* - using date of publication
CQC Domain: Effective
Month: July 2022
Target:

** Data contained in each Trust Reporting month covers provider data for the year of data running to four months prior to the stated month. i.e., Jun-22 data covers the period March 2021 to February 2022. May-22 data covers the period February 2021 to January 2022 and so forth*

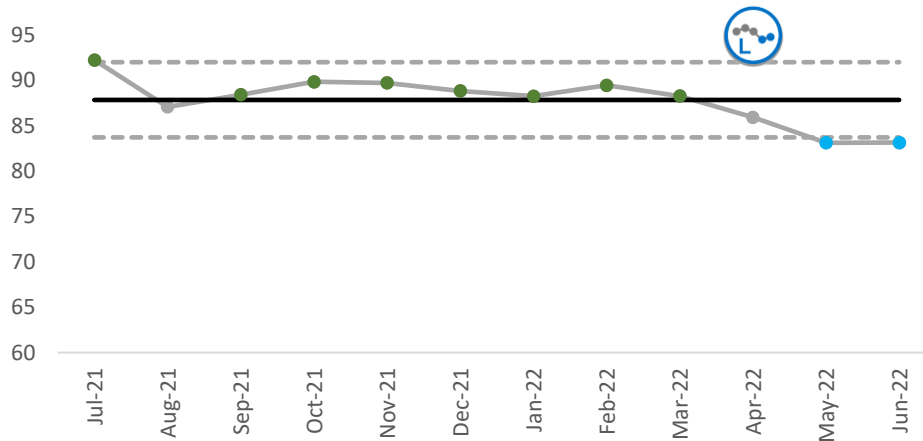
HSMR** - Using date of publication - CWH



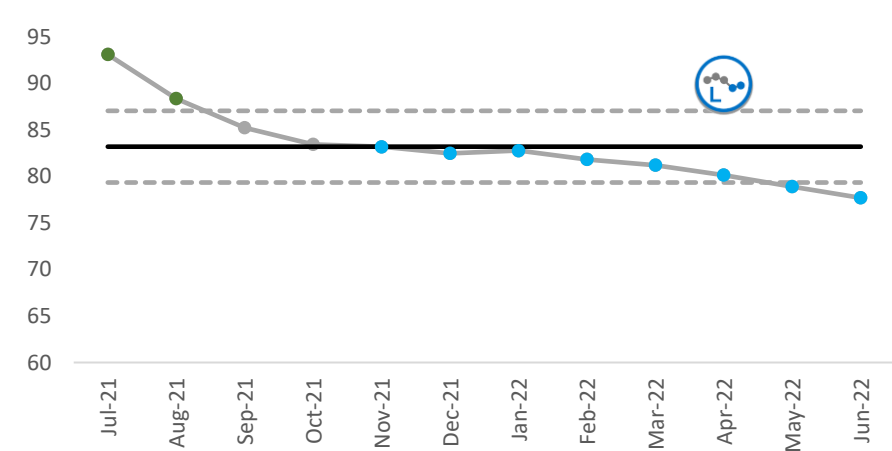
HSMR** - Using date of publication - ICH



HSMR** - Using date of publication - THH



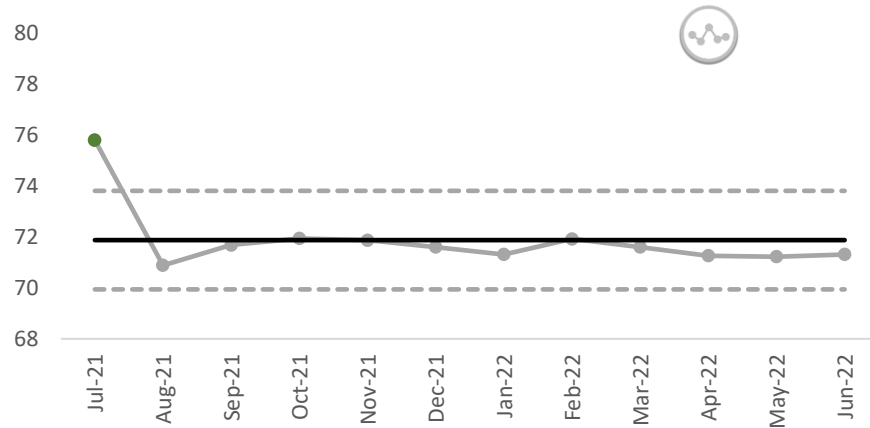
HSMR** - Using date of publication - LNWH



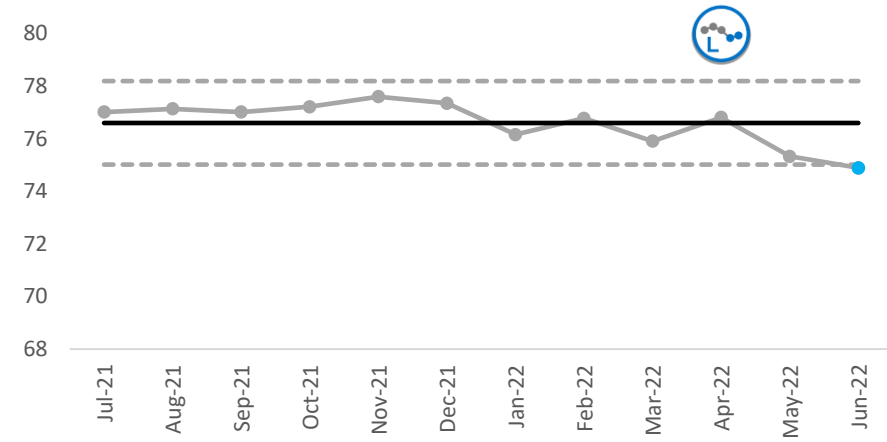
Metric: SHMI* - using date of publication
CQC Domain: Effective
Month: July 2022
Target:

* Data contained in each Trust Reporting month covers provider data for the year of data running to four months prior to the stated month. i.e., Jun-22 data covers the period March 2021 to February 2022. May-22 data covers the period February 2021 to January 2022 and so forth

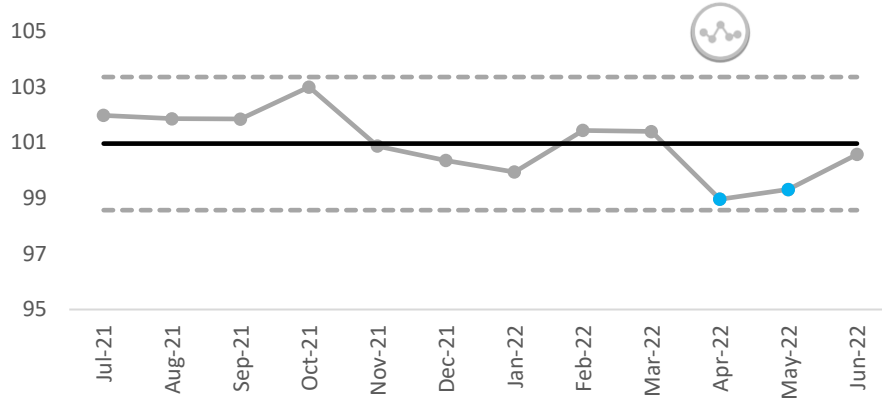
SHMI - Using date of publication - CWH



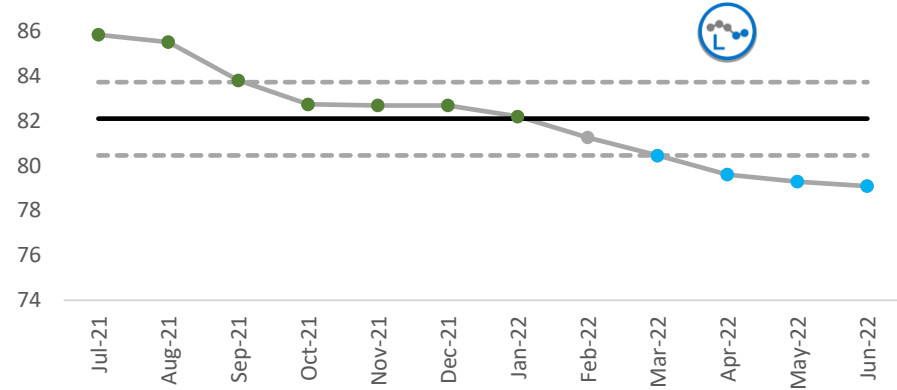
SHMI - Using date of publication - ICH



SHMI - Using date of publication - THH



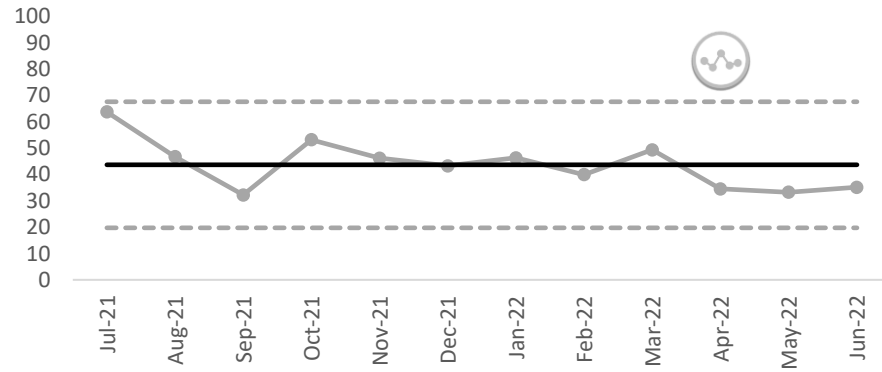
SHMI - Using date of publication - LNWH



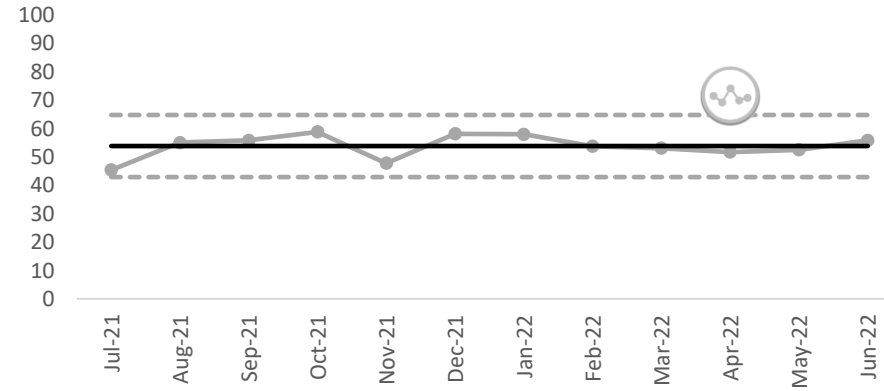
Metric: HSMR Palliative Care* - using date of publication
CQC Domain: Effective
Month: July 2022
Target:

* Data contained in each Trust Reporting month covers provider data for the year of data running to four months prior to the stated month. i.e., Jun-22 data covers the period March 2021 to February 2022. May-22 data covers the period February 2021 to January 2022 and so forth

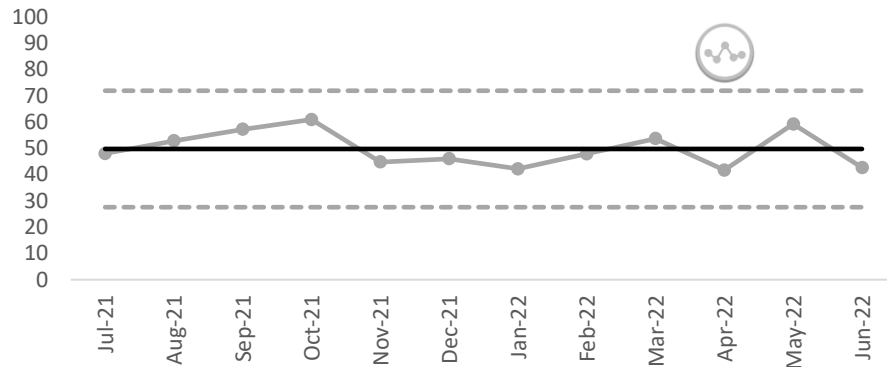
Palliative Care Coding rate (HSMR) - Using date of publication - CWH



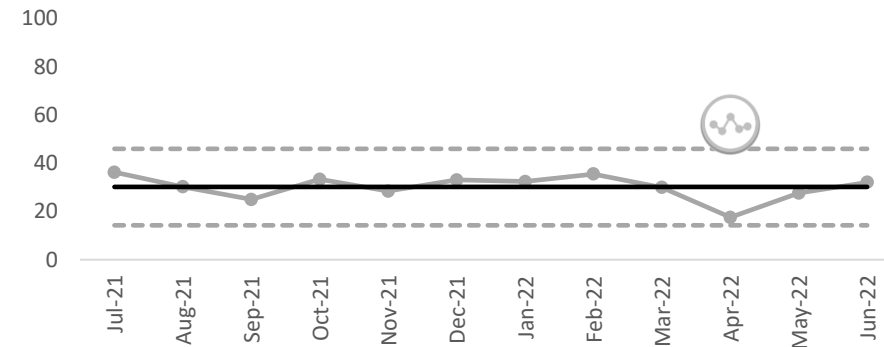
Palliative Care Coding rate (HSMR) - Using date of publication - ICH



Palliative Care Coding rate (HSMR) - Using date of publication - THH



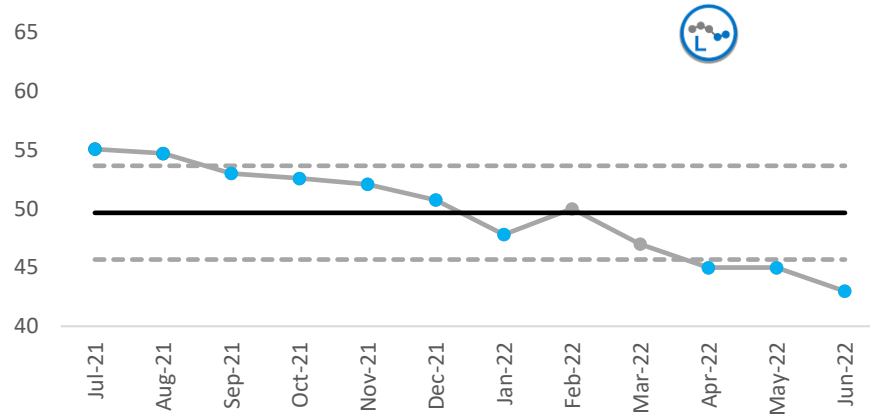
Palliative Care Coding rate (HSMR) - Using date of publication - LNWH



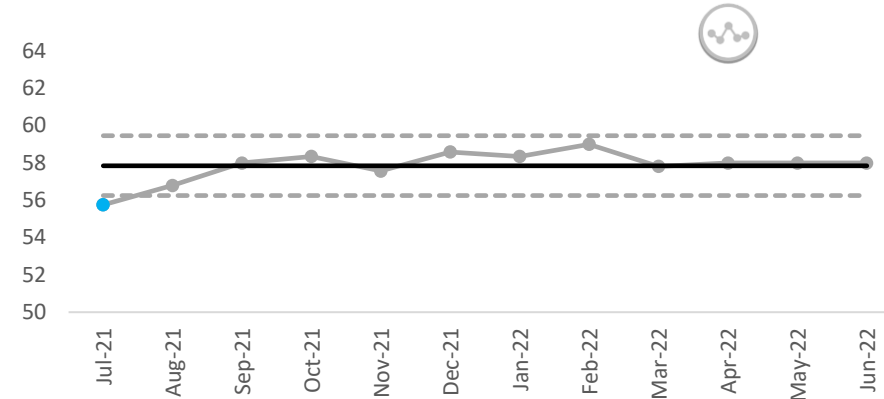
Metric: SHMI Palliative Care* - using date of publication
CQC Domain: Effective
Month: July 2022
Target:

* Data contained in each Trust Reporting month covers provider data for the year of data running to four months prior to the stated month. i.e., Jun-22 data covers the period March 2021 to February 2022. May-22 data covers the period February 2021 to January 2022 and so forth

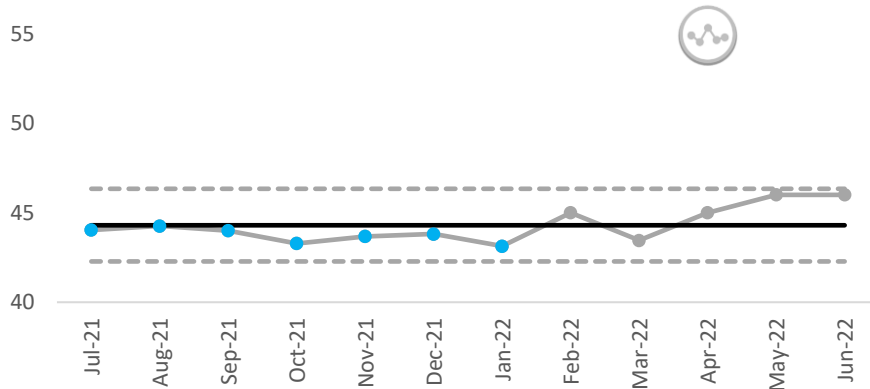
Palliative Care Coding rate (SHMI) - Using date of publication - CWH



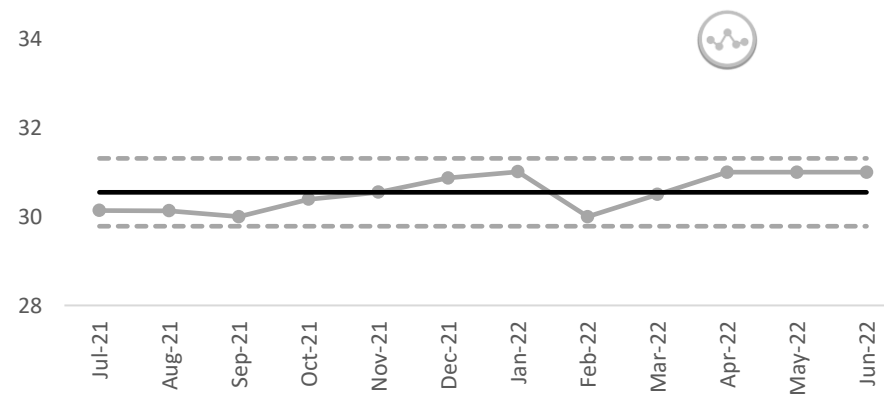
Palliative Care Coding rate (SHMI) - Using date of publication - ICH



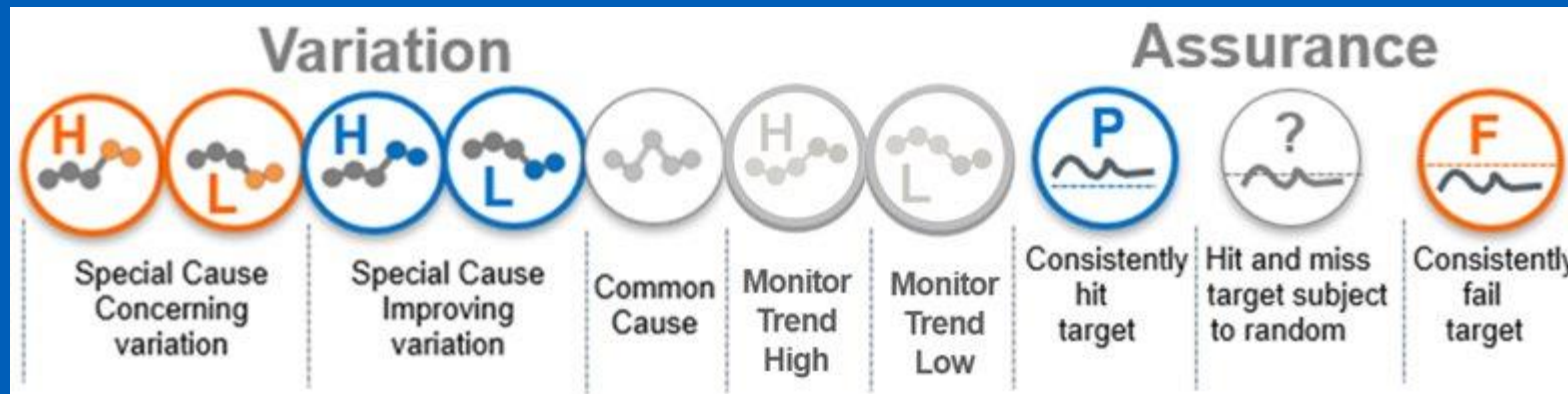
Palliative Care Coding rate (SHMI) - Using date of publication - THH



Palliative Care Coding rate (SHMI) - Using date of publication - LNWH



Notes: SPC charts - Key



Further information on Making Data Count
<https://www.england.nhs.uk/publication/making-data-count/>



NWL Acute Provider Collaborative People Performance

Executive Summary

Executive Summary: Vacancy rates at collaborative level are a common cause variation within the upper process limit albeit with hit and miss target achievement and variation at Trust level. Across the Acute Collaborative are currently at 11.4% and have been slowly increasing since April 2022, correlating to a rise in staffing turnover levels as well as establishment changes through budget setting for 2022/23.

Voluntary turnover has been increasing across all Trusts for the past six months and is a special cause concern variation and, with the exception of LNWUH, is over target at Trust level; a trend also reflected in other industries. As we approach winter, and its associated pressures on staffing through activity and sickness, reducing turnover levels where possible through increased retention is of priority.

The past 12-months has seen a continued increase in the rolling sickness absence rate and is a special cause concern for the Collaborative with impacts of COVID absence and Monkey Pox on staffing absence. July 2022 saw increased levels of sickness, due to higher levels of COVID illness; all staffing groups were affected with particular impact across nursing & midwifery and medical staffing with some services and theatre lists being cancelled due to lack of staff.

We are currently working towards an Acute Collaborative target for this measure with two Trusts currently reporting this against local target; Imperial at 2% and LNWUH at 4%

Completion rates, for both non-medical and medical Performance Development Reviews (PDR) and appraisals, is an area of concern with no Trust meeting target for both measures and we are currently working towards an agreed Acute Collaborative target for both of these measures to drive improvement

All Trusts across the collaborative perform well against their individual targets for Core Skills compliance but we are starting to see a reduced overall Collaborative position

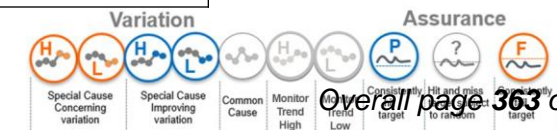
Collectively we are reporting an over-establishment of 268 whole time equivalent (WTE) against the reported post establishment WTE position; driven by higher levels of temporary staffing during July 2022. Increased sickness cover requirement, vaccination staffing and elective recovery plans are the main drivers for this over-establishment but it is essential to ensure, at Trust level, that we are reporting the correct establishment figures to accurately reflect this and is an action for providers during September

Escalations by Theme:

- Increasing levels of sickness absence
- Increasing levels of voluntary turnover
- High levels of vacancies with specific hard to recruit roles and gaps
- Trust and Collaborative preparedness and planning for winter

People Scorecard

Workforce Performance Metrics				
Metric	CWFT	ICHT	THH	LNW
Vacancy Rate				
Voluntary Turnover Rate				
Sickness Absence Rate - In month				
Sickness Absence Rate - Rolling 12 months				
Agency Spend as % of Paybill	not reported against target		not reported against target	
PDR/Appraisal Completion Rate - non medical				
Medial Appraisal Completion Rate				
Core Skills Compliance Rate				



Vacancies

Acute Provider Collaborative Summary:

- Vacancy rates at collaborative level are a common cause variation within the upper process limit albeit with hit and miss target achievement and variation at Trust level
- Vacancy levels across the Acute Collaborative are currently at 11.4% and have been slowly increasing since April 2022, correlating to a rise in staffing turnover levels as well as establishment changes through budget setting for 2022/23
- Hard to recruit roles, due to a shortage of qualified staff, such as Sonographers, Occupational Therapists, Middle Grades for Emergency Medicine and Pathology continue to be of concern with an increasing 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
- Midwives, Sonographers, Physiotherapists, Occupational Therapists, Speech & Language Therapists, Healthcare Scientists and band 5 nursing roles are of current concern with continuing international recruitment campaigns, rolling recruitment and targeted recruitment campaigns to reduce vacancies
- High levels of vacancies, as we move into the winter period, will put additional pressure on bank staffing demand at a time of increased activity and sickness (seasonal & COVID)
- The strong pipeline of band 2/3 Healthcare Support Workers (HCSW), from the North West London joint recruitment event, have begun to join Trusts as well as internationally appointed nurses, including those who have joined already (in a HCSW capacity) and awaiting their OSCE to practice as registered nurses
- Winter planning is well under way, including recruitment into specific and key roles supporting pathway and care delivery as well as winter incentives for bank workers to increase fill-rates
- The Capital Midwives programme has been successful in recruiting more midwives with a successful open day held in June with another planned in September / October
- A Collaborative bid for £4k per AHP recruit has been submitted to the Capital Consortium with business case in progress to recruit AHPs

Acute Provider Collaborative Actions:

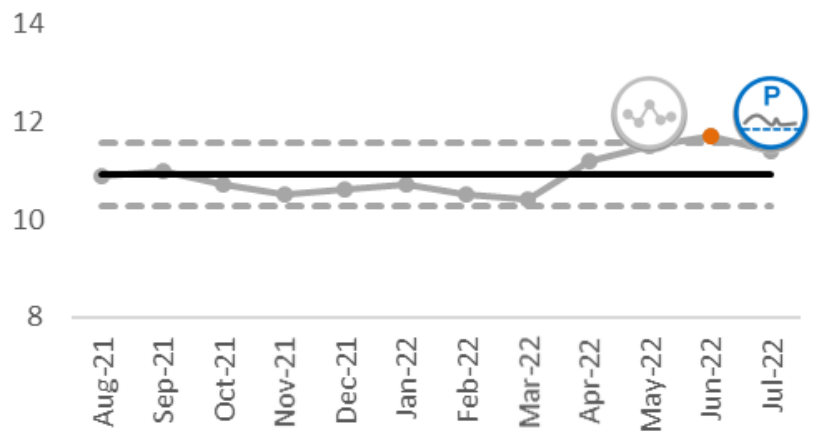
- Agree a Collaborative target to drive focus and improvement
- Reduce the time to hire (TTH) to bring new staff on-board earlier
- International recruitment campaigns for nursing, midwifery and AHP roles
- Recruitment into resourcing team vacancies to support and expedite recruitment
- ACC programme for the development and use of robotics to improve recruitment process
- Recruitment to fill key patient pathway roles as part of winter planning
- Winter incentives to increase bank fill of shifts is being agreed
- Timely rostering and management of leave essential to maintaining staffing levels
- Proactive conversion of nursing & midwifery students into substantive qualified vacancies
- Retention of staff and staff development to reduce numbers of staff leaving

Acute Provider Collaborative Assurance & Timescales for improvement

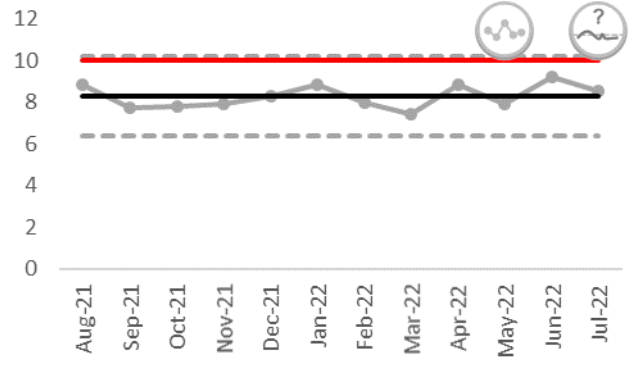
- To be discussed and agreed by CPOs
- In place at Trust & Collaborative level with internal monthly monitoring
- In place Trust & Collaborative level with both internal and external monthly monitoring
- Commenced with successful candidates joining during September & October
- Commenced with road map of delivery established and in action
- Commenced with aim to bring recruits on-board from October
- Currently under discussion for agreement by CPO's
- In place with monthly monitoring of roster sign off and unavailability at Trust level
- In place with newly registered nurses & midwives joining during September & October
- In place at Trust level through retention task & finish groups

Metric: Vacancy Rate %
CQC Domain: Safe
Month: July 2022
Target: TBC

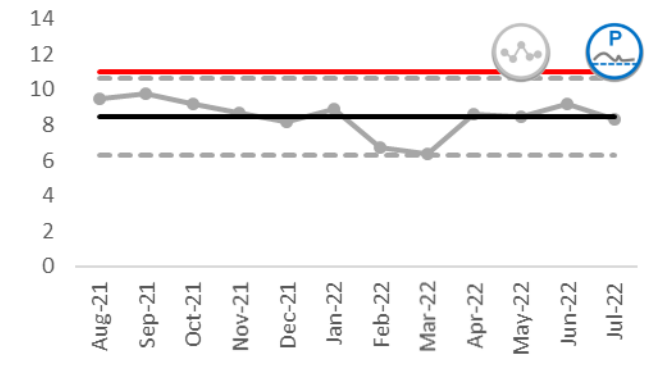
Acute Collaborative - Vacancy Rate %



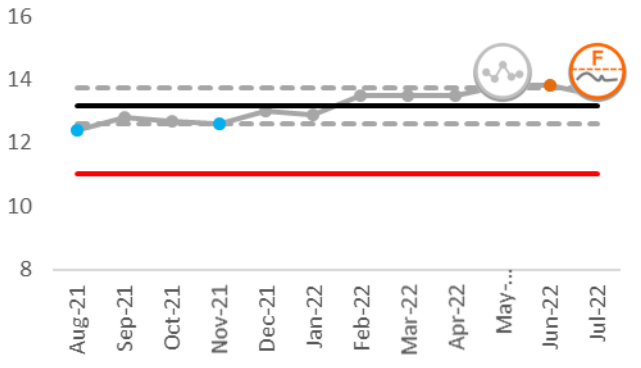
Chelsea & Westminster - Vacancy Rate %



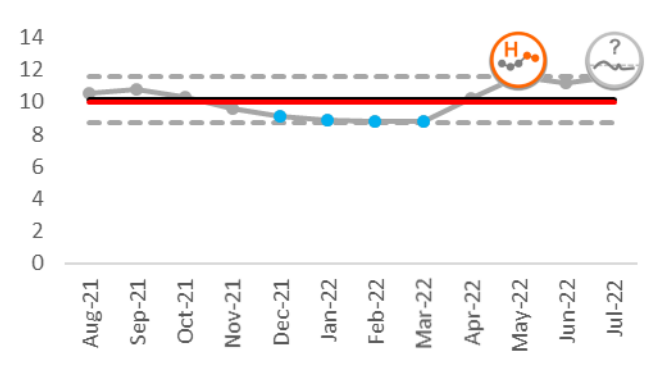
Hillingdon - Vacancy Rate %



Imperial - Vacancy Rate %



London North West - Vacancy Rate %



Voluntary Turnover

Acute Provider Collaborative Summary:

- Voluntary turnover has been increasing across all Trusts for the past six months and is a special cause concern variation and, with the exception of LNWUH, is over target at Trust level; a trend also reflected in other industries
- As we approach winter, and its associated pressures on staffing through activity and sickness, reducing turnover levels where possible through increased retention is of priority
- 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 requires improvement in the capture and recording of this data to inform retention plans
- Understanding the proportion of leavers moving from Trust to Trust within the Acute Collaborative and North West London sector is key in improving retention and requires us to work together for joint solutions such as cross-Trust rotations and career pathways and a deep-dive analysis into leavers data is underway
- Exit interviews and Stay Conversations continue and in particular for hotspot areas such as ICU, Midwifery and AHP, with feedback and insight being fed back into Trust retention plans and actions
- Staff wellbeing is a key enabler in improving retention and each Trust has a well established package of wellbeing support, shared and improved upon through the Collaborative platform, for all members of staff
- The current cost of living issue is one which we are taking seriously and our Trusts are working together, though their Chief People Officers (CPOs), to agree a common approach to support staff over the coming months

Acute Provider Collaborative Actions:

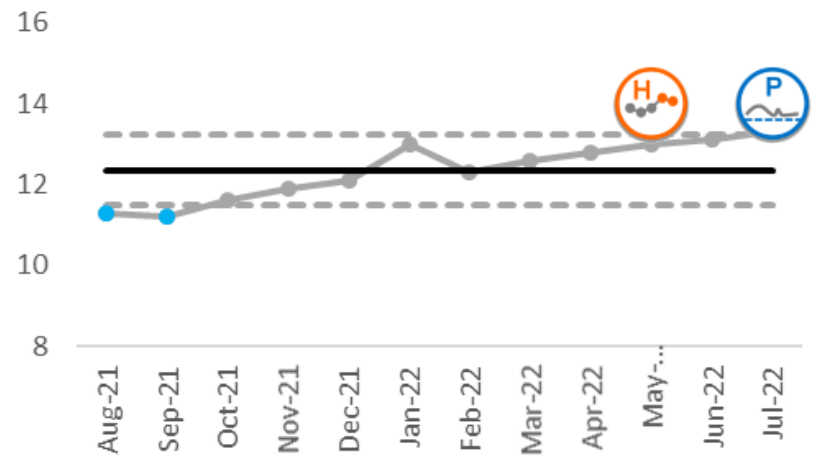
- Agree a Collaborative target to focus action and improvement
- Collaborative support measures to be agreed for staff regards cost of living issue
- Deep-dive analysis into leaving reasons and destinations to inform improvement actions
- Retention Task & Finish Groups and workshops at both Trust and Sector level for improvement
- Exit interviews, including targeted conversations in hotspot areas, to inform action and improvement
- Cross-Trust rotations and career pathways to retain staff within the Collaborative
- Improve data capture quality for leavers reducing the proportion of 'other/not known' to inform action and improvement

Acute Provider Collaborative Assurance & Timescales for improvement

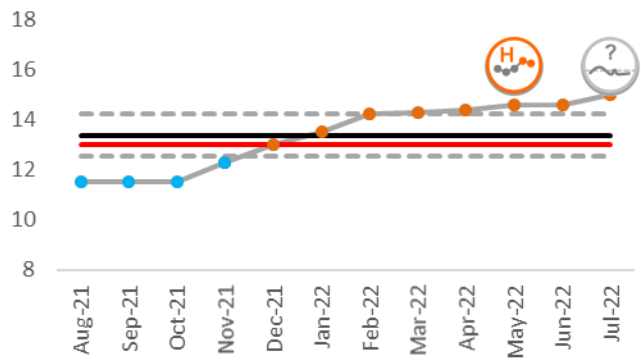
- To be discussed and agreed by CPOs
- Currently under discussion for agreement by CPO's
- Underway with analysis complete and shared with CPO's in October
- In place at Trust level with monthly monitoring with Sector level workshop being re-scheduled
- In place at Trust level with insights shared with directorates and service leads to inform retention plans
- For discussion with CPOs in November following deep-dive leavers analysis
- For prioritisation and improvement within Trusts following discussion and agreement with CPOs

Metric: Voluntary Turnover Rate %
CQC Domain: Well Led
Month: July 2022
Target: TBC

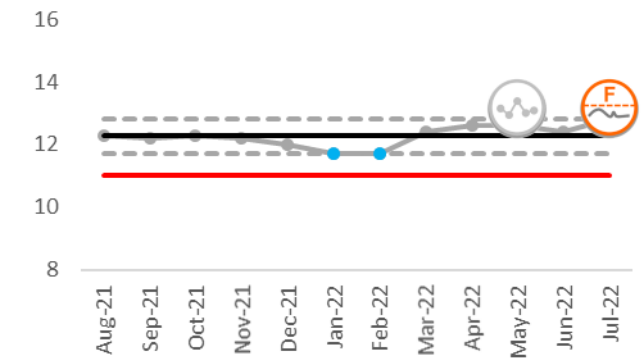
Acute Collaborative - Turnover Rate %



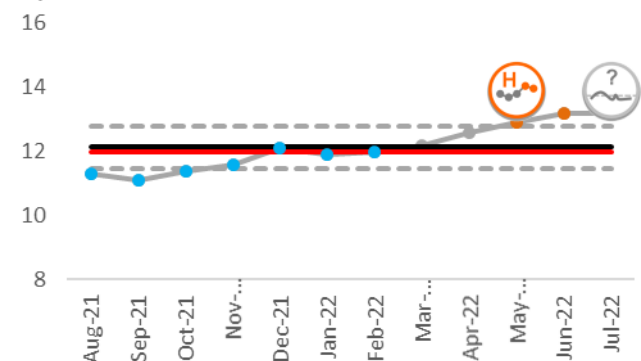
Chelsea & Westminster - Turnover Rate %



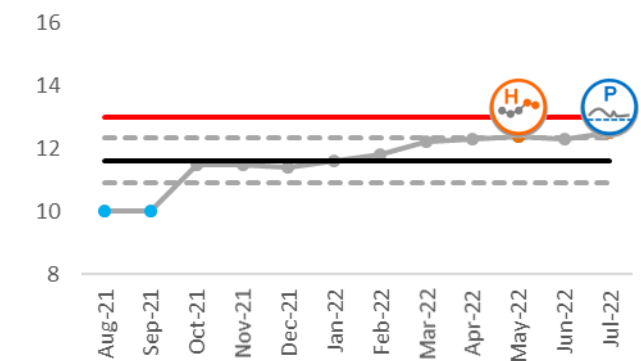
Hillingdon - Turnover Rate %



Imperial - Turnover Rate %



London North West - Turnover Rate %



Sickness Absence

Acute Provider Collaborative Summary:

- The past 12-months has seen a continued increase in the rolling sickness absence rate and is a special cause concern for the Collaborative with impacts of COVID absence and Monkey Pox on staffing absence
- June and July 2022 saw increased levels of sickness, due to higher levels of COVID illness; all staffing groups were affected with particular impact across nursing & midwifery and medical staffing with some services and theatre lists being cancelled due to lack of staff
- Trusts worked locally to re-deploy staff and mitigate safe staffing risks which resulted in a higher reliance on temporary staff with increased numbers of bank and agency shifts
- Vaccination uptake (FLU & COVID booster) will be a key component of managing sickness absence through the winter months as will annual leave management over the Christmas and New Year periods, which have a four and a three day bank holiday weekend, to ensure safe staffing levels
- Management of both long and short term sickness is active across all Trusts including, policy training, revision of the absence policy and robust reporting for managers in support of this
- 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 and its impact will to be a key focus for all Trusts over the coming months
- Sickness levels are centrally captured and monitored daily with weekly reporting to North West London Gold (NWL Gold), within this we monitor the levels of COVID absence to alert for increasing numbers to inform planning for both staffing and patient pathways
- Of increasing importance is the analysis and insight of sickness absence data and intelligence to inform intervention and action at local and Collaborative level and this is now possible with the establishment of a shared data platform as part of the ACC digital programme

Acute Provider Collaborative Actions:

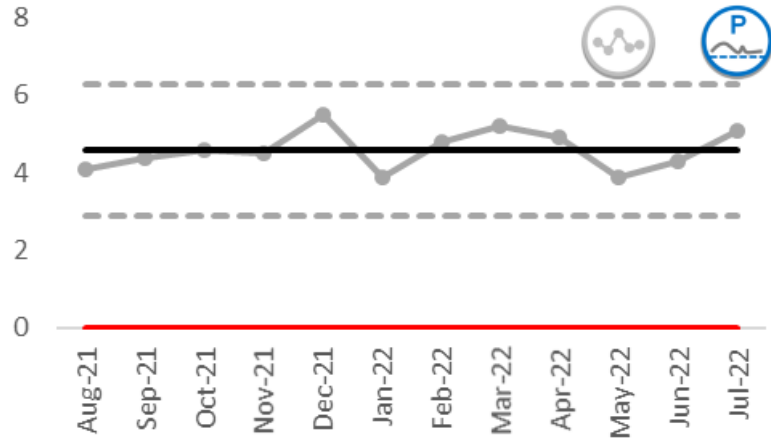
- Agree a Collaborative target for sickness absence to drive focus and improvement
- Daily monitoring of sickness with escalation and regular reporting to NWL Gold
- Annual leave management for Christmas and New Year periods (4 and 3 day BH)
- Vaccination programme (FLU & COVID) to minimise impact on staffing
- Provision of staff psychology and health & well being services
- Pre-planning for staff re-deployment and adjusted staff to patient ratios
- Review of sickness policy and manager training for effective absence management
- Deep-dive sickness analysis and insight reporting to inform action & intervention
- Monitoring and management of short and long-term sickness to support staff and teams

Acute Provider Collaborative Assurance & Timescales for improvement

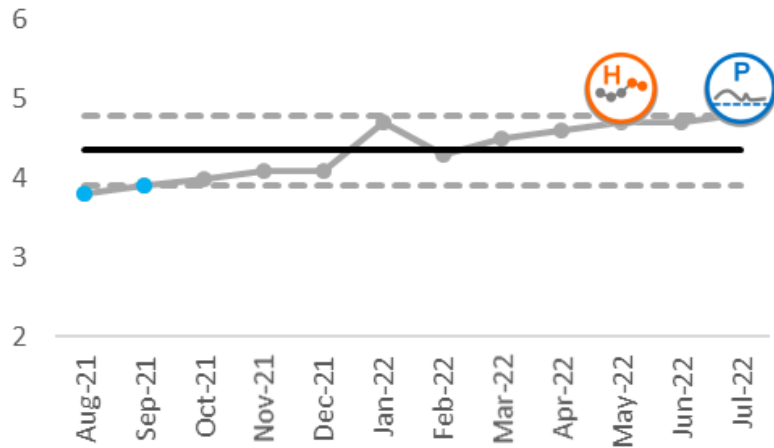
- To be discussed and agreed with CPOs
- In place and monitored daily with weekly reporting and escalation as required
- In place with monthly monitoring of roster sign off and unavailability at Trust level
- Commenced at Trust level through local vaccination roll-out and take-up plans
- In place within each Trust and monitored for changes in demand and responsiveness
- Commenced at Trust level through local winter planning preparedness
- In place with various supportive measures such as audits and focussed hotspot actions
- Now available through the shared Collaborative digital platform
- In place at individual, department and divisional levels across all Trusts supported through reporting and analysis

Metric: Sickness Absence Rate %
CQC Domain: Safe
Month: July 2022
Target: TBC

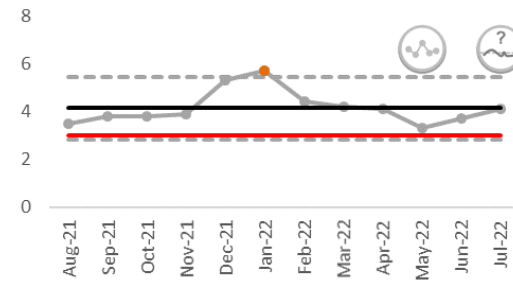
Acute Collaborative - Monthly Sickness Rate %



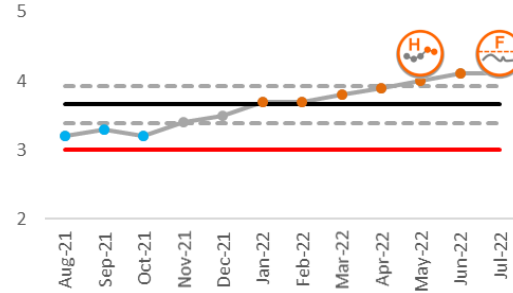
Acute Collaborative - Rolling Sickness Rate %



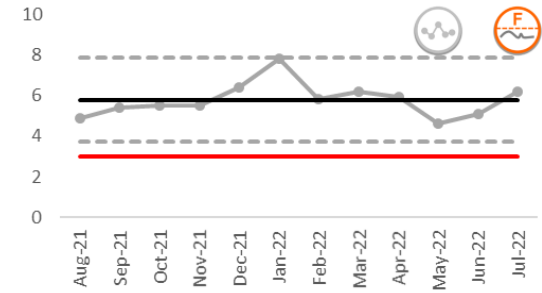
Chelsea & Westminster - Monthly Sickness Rate %



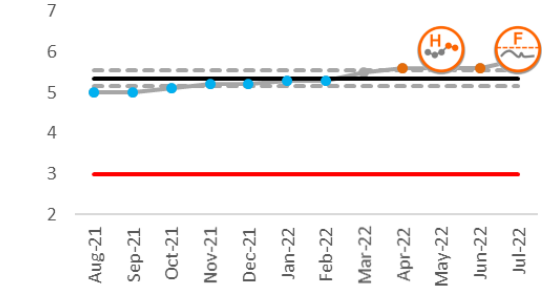
Chelsea & Westminster - Rolling Sickness Rate %



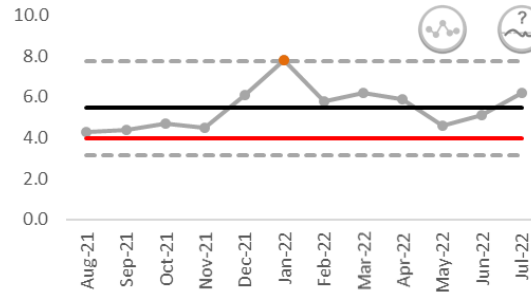
Hillingdon - Monthly Sickness Rate %



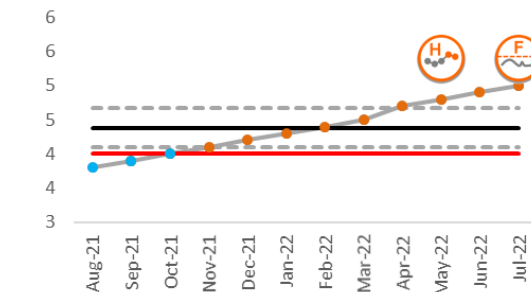
Hillingdon - Rolling Sickness Rate %



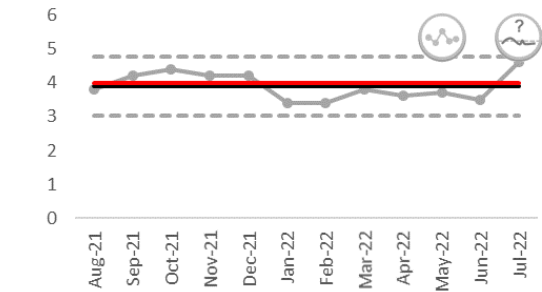
Imperial - Monthly Sickness Rate %



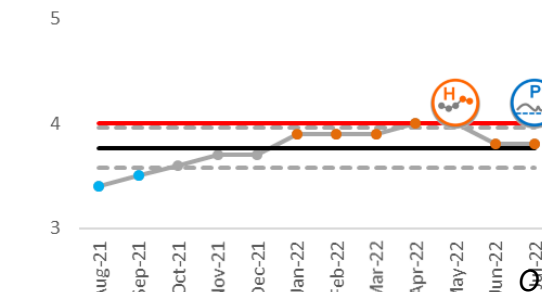
Imperial - Rolling Sickness Rate %



London North West - Monthly Sickness Rate %



London North West - Rolling Sickness Rate %



Agency Spend

Acute Provider Collaborative Summary:

- We are currently working towards an Acute Collaborative target for this measure with two Trusts reporting this against local target; Imperial at 2% and LNWUH at 4%
- Governance, management and monitoring at Imperial includes a Trust wide productivity and efficiency scheme to reduce agency spend to two per cent of the pay budget; year to date position at 3.3%
- At Chelsea & Westminster, working groups and the Trust Executive team assess the levels of temporary staffing requests weekly including triangulation against reasons for booking to identify support and any further controls required to control, monitor and utilise agency in an effective and efficient manner
- Increased agency spend during July at Hillingdon increase has been seen across nursing and medical staff, though Framework Escalations being utilized to remove Off-Framework Suppliers. The Non-clinical pay control processes and the focus on converting long term agency medics is ongoing and work continues to tighten governance arrangements in using RMNs and monitoring medical variable pay spent
- 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 due such as sonography and pathology
- The Collaborative Trusts are working together to share and agree winter bank incentives which will be key in reducing the requirement for agency cover as well as increased recruitment activity to existing vacancies
- In addition, recruitment to the Trust Staff Banks is ongoing and a key in reducing agency reliance and spend; supported by the Collaborative Bank work including agreement that all shifts are advertised on this platform 21 days priori to shift date

Acute Provider Collaborative Actions:

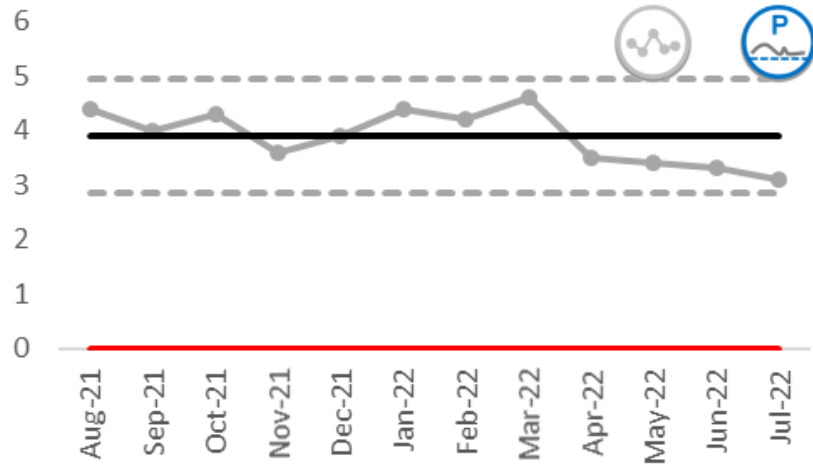
- Agree an Acute Collaborative target for agency spend to focus action and improvement
- Reduced vacancies for hard to fill roles to minimise agency reliance and spend
- Recruitment to bank for wide-range of roles to reduce agency reliance and spend
- Understand collective impact of special ling and RMN requirement on agency demand
- Ensure robust controls and authorisation is in place for agency bookings
- Enhanced bank rates for specific roles to avoid agency fill
- Use of the direct engagement model to minimise agency spend
- Minimisation of off-framework bookings to manage spend
- Improve Allied Health Professional and Healthcare Scientist provision through the bank

Acute Provider Collaborative Assurance & Timescales for improvement

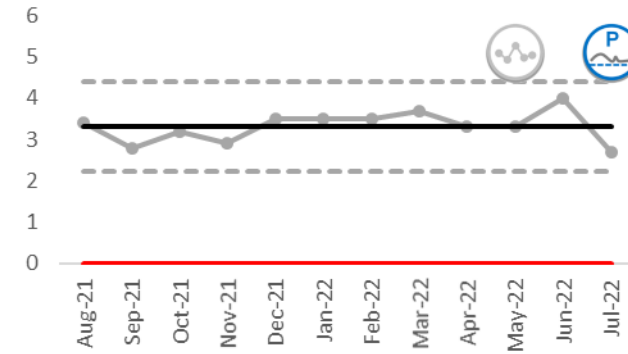
- To be discussed and agreed with CPOs
- In place with Trust and collective recruitment campaigns and incentives
- In place at Trust level through auto-enrolment and recruitment campaigns
- To be discussed by CPOs to commence as soon as possible to drive collaborative solution
- In place at Trust level through a range of measures
- In place at Trust level with Collaborative agreement where possible
- In place at Trust level with quantifiable reductions in spend
- In place at Trust level through governance, controls and measures
- In place at Trust level through targeted recruitment campaigns

Metric: Agency Spend
CQC Domain: Well Led
Month: July 2022
Target: TBC

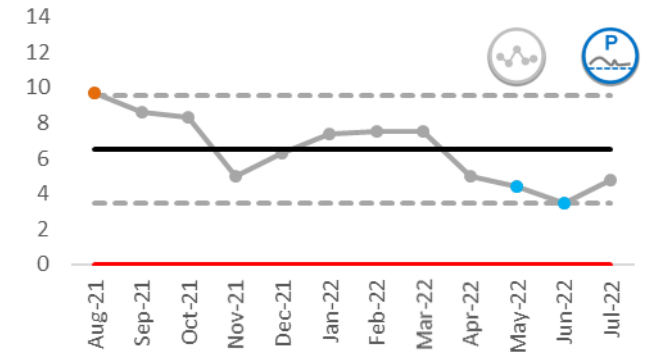
Acute Collaborative - Agency Spend % of Paybill



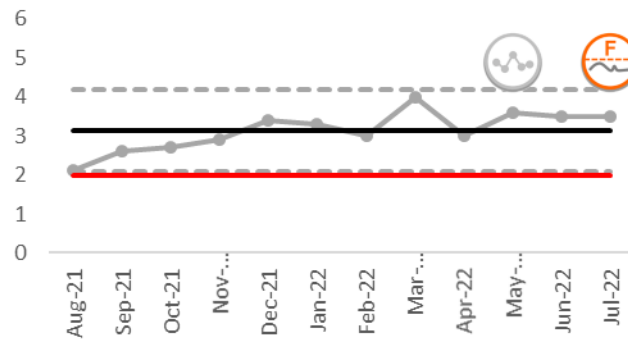
Chelsea & Westminster - Agency Spend % of Paybill



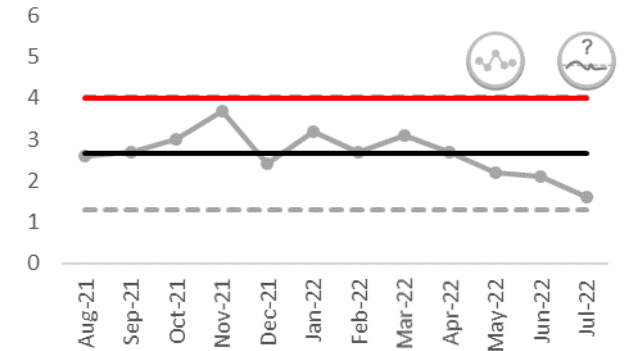
Hillingdon - Agency Spend % of Paybill



Imperial - Agency Spend % of Paybill



London North West - Agency Spend % of Paybill



PDR / Appraisal

Acute Provider Collaborative Summary:

- Completion rates, for both non-medical and medical Performance Development Reviews (PDR) and appraisals, is an area of concern with no Trust meeting target for both measures and we are currently working towards an agreed Acute Collaborative target for both of these measures to drive improvement
- With the exception of Imperial, who have a specific non-medical PDR season (April – July), all Trusts have a rolling target for medical and non-medical appraisal and PDR compliance supporting the development, well being and engagement of our staff
- Continued focus is required across all Trusts to improve compliance against these core workforce metrics, supported through regular monitoring, reporting and actions for improvement
- Continued engagement with line managers and supervisors is essential to complete all reviews as is additional support where needed to ensure that all staff have this essential conversation with their manager
- Operational pressures, as well as high levels of sickness absence, have contributed to the challenge of conducting and completing the appraisal and PDR conversations and, as we approach a period of heightened activity and seasonal sickness, a local review of support for managers is needed

Acute Provider Collaborative Actions:

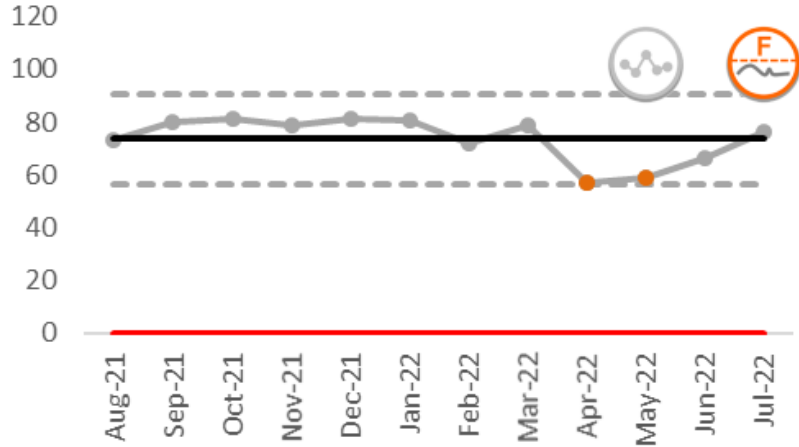
- Focus on areas of low compliance to support and improve completion of appraisal
- Agreement of Collaborative targets for medical and non-medical appraisal
- Continued engagement with supervisors and line managers to drive improvement
- Protected time to carry-out appraisals with backfill for staff

Acute Provider Collaborative Assurance & Timescales for improvement

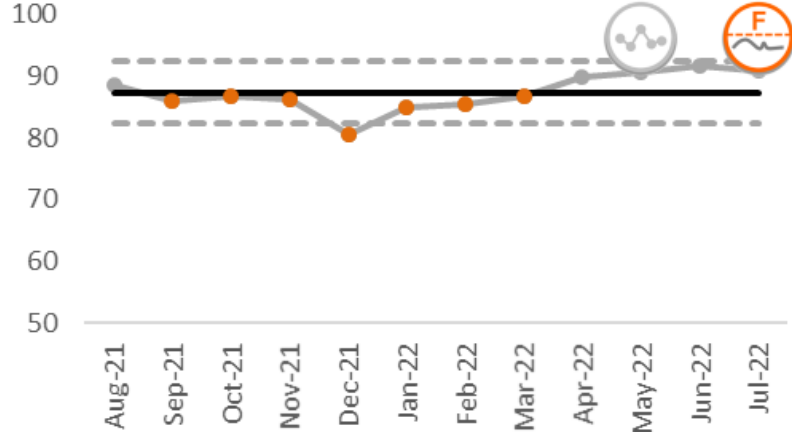
- In place regular monitoring and reporting of compliance at all organisational levels
- To be discussed and agreed by CPOs
- In place through local divisional and directorate monitoring and discussion
- To be discussed with CPOs

Metric: PDR / Appraisal
CQC Domain: Well Led
Month: July 2022
Target: TBC

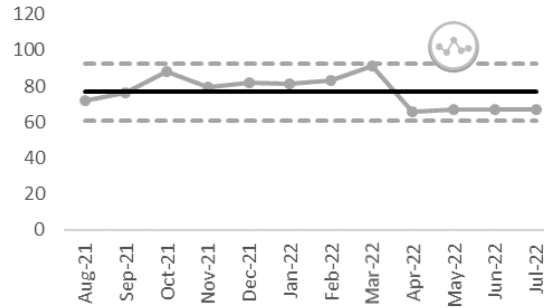
Acute Collaborative - PDR Completion Rate %



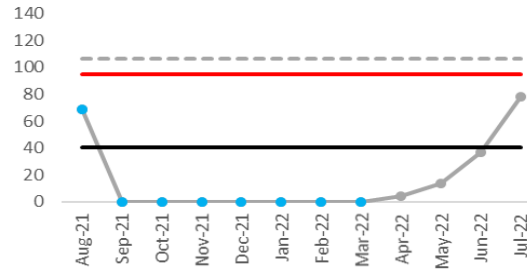
Acute Collaborative - Medical Appraisal Rate %



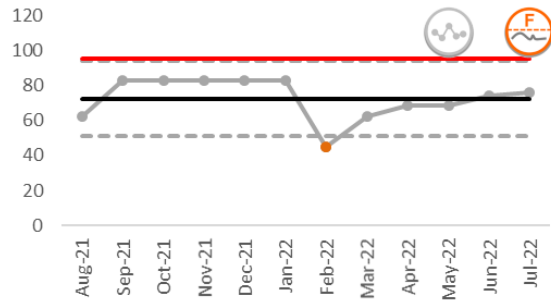
Chelsea & Westminster - PDR Completion Rate %



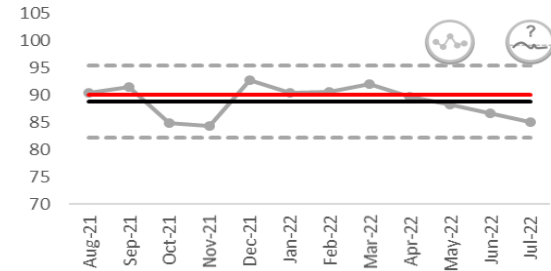
Imperial - PDR Completion Rate %



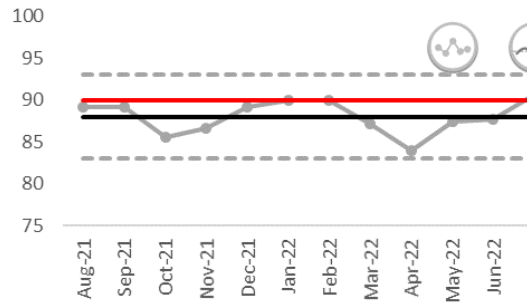
Hillingdon - PDR Completion Rate %



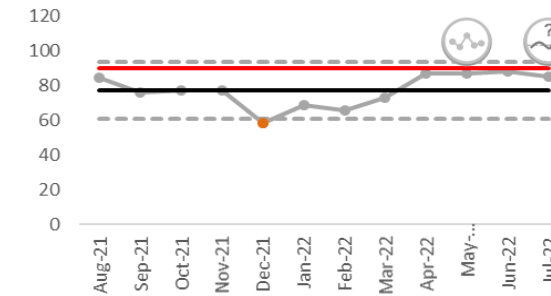
London North West - PDR Completion Rate %



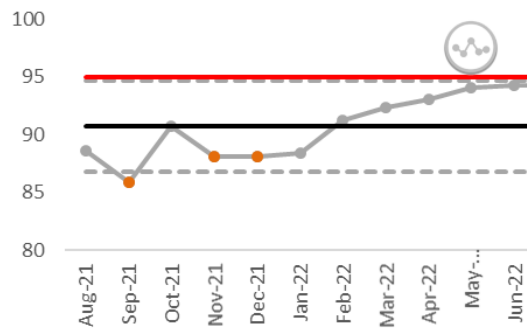
Chelsea & Westminster - Medical Appraisal Rate %



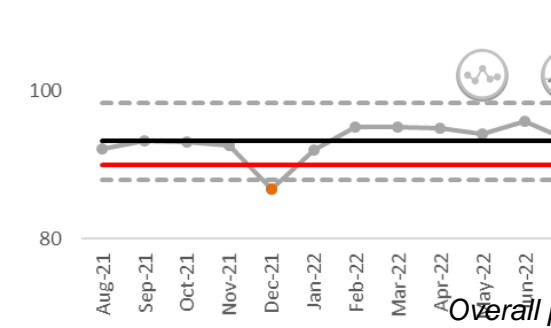
Hillingdon - Medical Appraisal Rate %



Imperial - Medical Appraisal Rate %



London North West - Medical Appraisal Rate %



Core Skills Compliance

Acute Provider Collaborative Summary:

- Core Skills 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 perform well against their individual targets for Core Skills compliance but we are starting to see a reduced overall Collaborative position
- An agreed Acute Collaborative target for this essential workforce metric will be discussed and agreed by the Chief People Officers
- Topic level performance monitoring and reporting is key to driving improvement with current areas for focus although some face to face training has been COVID safety restrictions
- The induction programme for doctors in training includes time for them to complete the online elements of their core skills training, which is essential during high rotation activity including August and February
- Where possible, auto-reminders are in place for both employees and their line managers to prompt renewal of core skills training as are individual online compliance reports

Acute Provider Collaborative Actions:

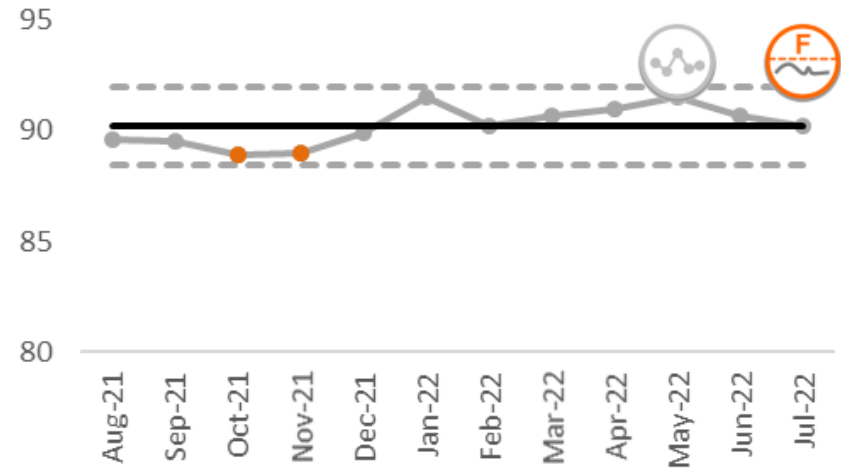
- Reminders of incomplete and expiring training by topic to alert individuals to take action
- Link core skills compliance with appraisal and PDR reviews to drive improvement
- Regular reporting of core skills compliance for managers and individuals to drive and maintain improvement

Acute Provider Collaborative Assurance & Timescales for improvement

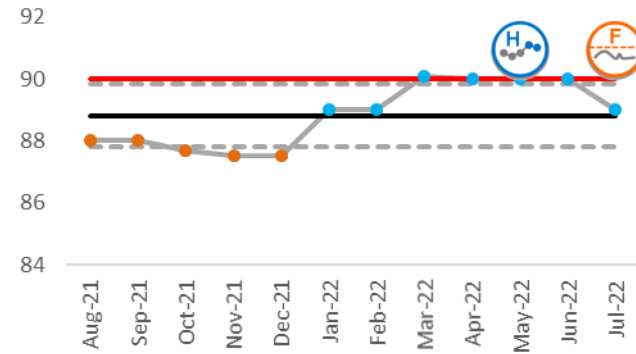
- In place through various system communications
- In place with action agreed at appraisal / PDR
- In place through various processes including online reporting

Metric: Core Skills Compliance
CQC Domain: Safe
Month: July 2022
Target: TBC

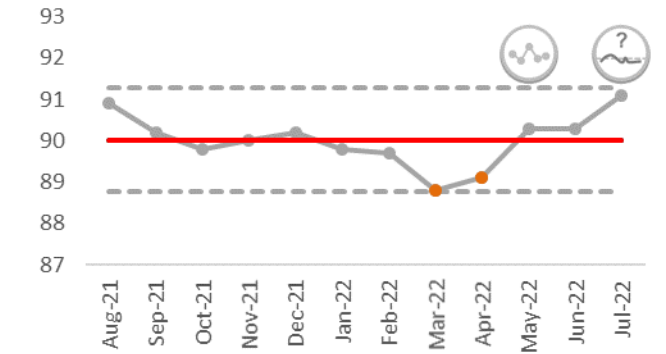
Acute Collaborative - Core Skills Rate %



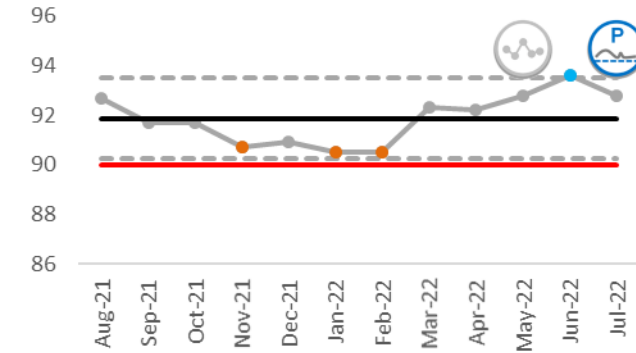
Chelsea & Westminster - Core Skills rate %



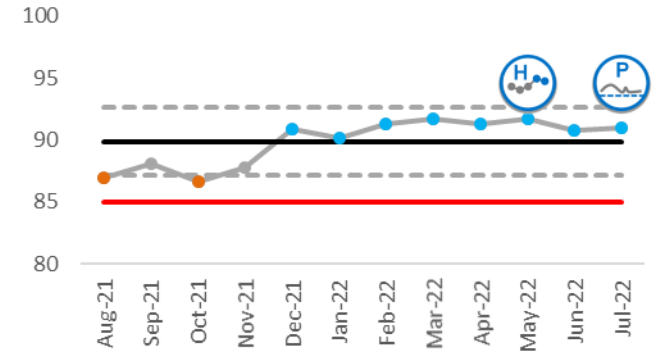
Hillingdon - Core Skills Rate %



Imperial - Core Skills Rate %



London North West - Core Skills Rate %



Establishment & Staffing

Acute Provider Collaborative Summary:

- Collectively we are reporting an over-establishment of 268 whole time equivalent (WTE) against the reported post establishment WTE position; driven by higher levels of temporary staffing during July 2022
- Increased sickness cover requirement, vaccination staffing and elective recovery plans are the main drivers for this over-establishment but it is essential to ensure, at Trust level, that we are reporting the correct establishment figures to accurately reflect this and is an action for providers during September
- At Trust level, only Imperial are reporting overall staffing levels within current post establishment with this margin decreasing during July due to increased sickness cover demand
- Current staffing levels, against the 2022/23 Operating Plan (Workforce) show that we are operating above plan by 456 WTE driven by higher than planned bank and agency usage and lower substantive numbers
- Depending on the cost of each booked bank and agency shift will dictate whether the increase levels of staffing is resulting in spend above pay budget and may not necessarily result in an overspend position

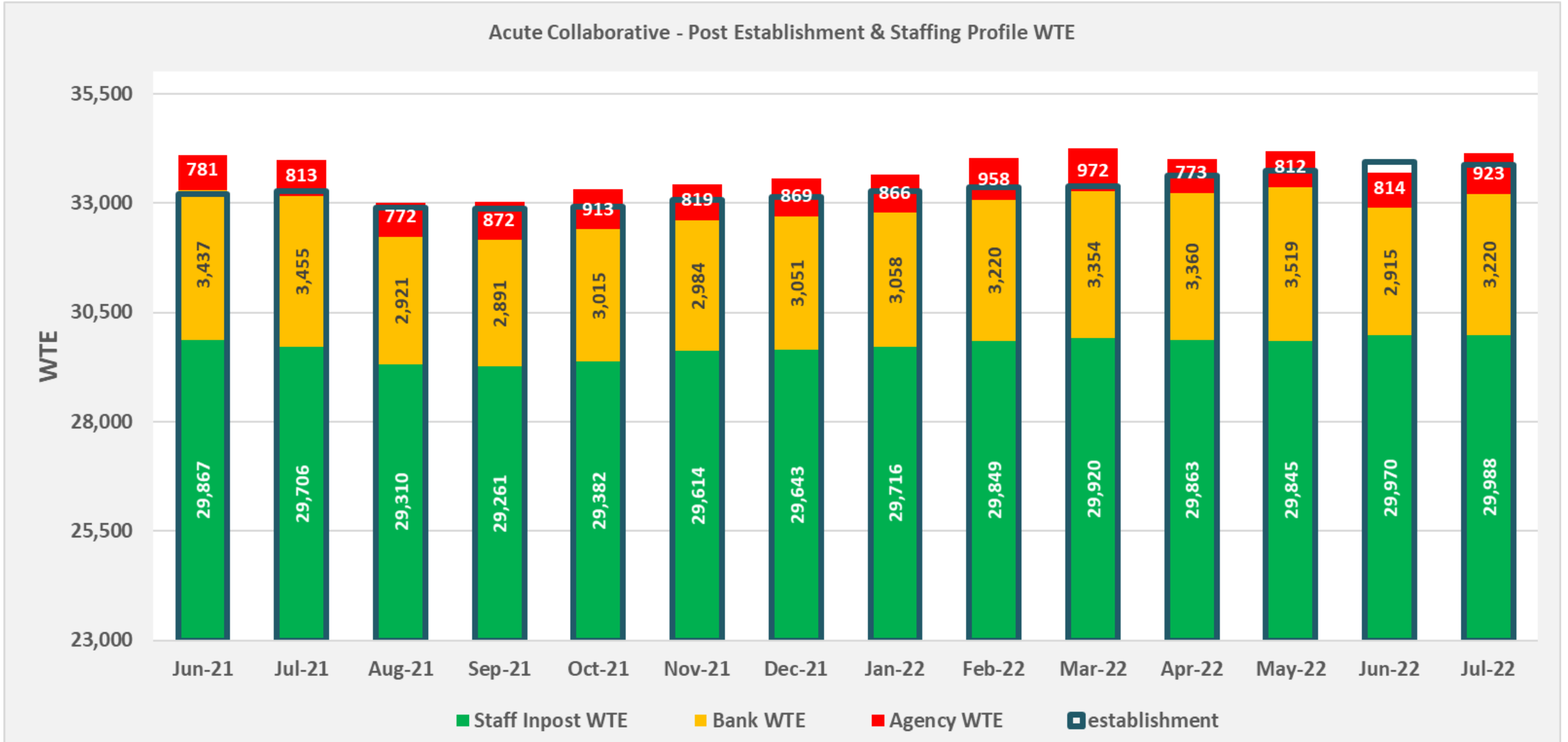
Acute Provider Collaborative Actions:

- Robust establishment control process to maintain integrity of the ESR post establishment and alignment with the General ledger
- Review of reported post establishment to ensure accuracy of reporting
- Regular review of vacant posts for service delivery requirements
- Timely recruitment for replacements and new posts to minimise impact on service delivery and temporary staffing reliance
- Understand the drivers for over-establishment and agree mitigations where required

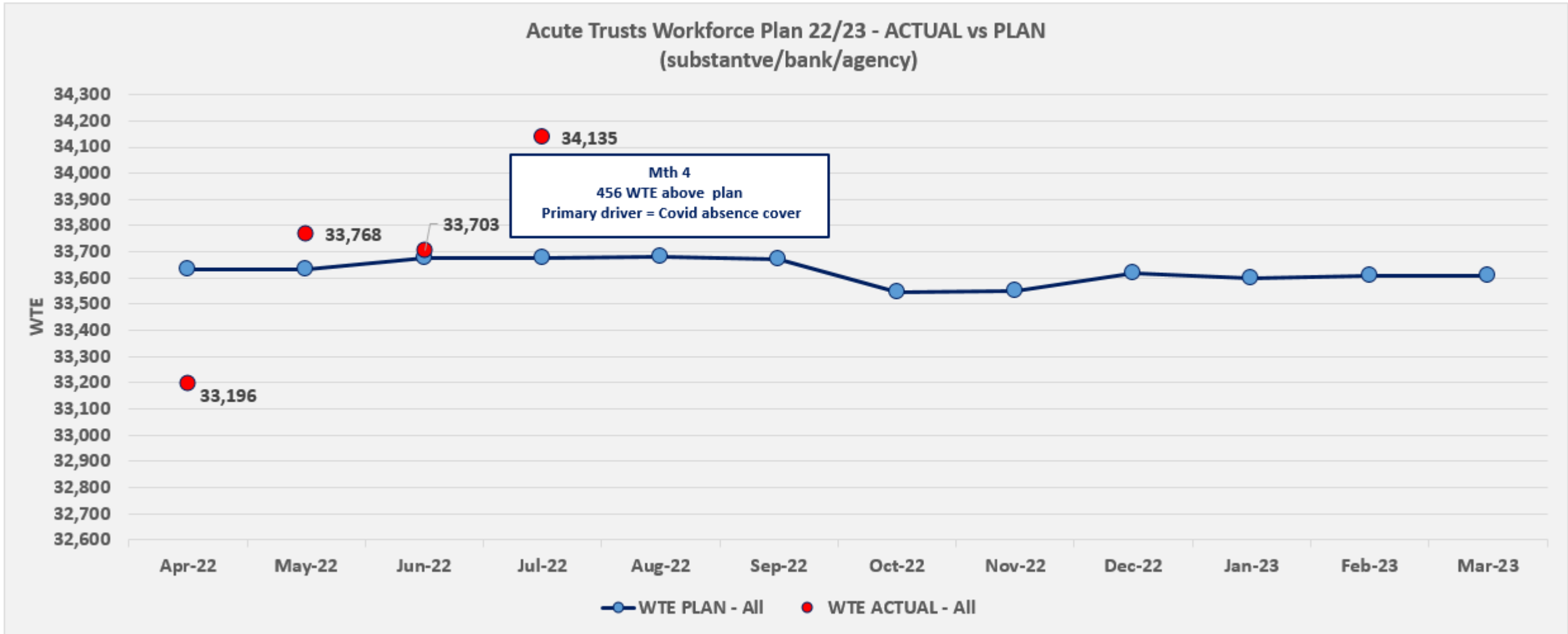
Acute Provider Collaborative Assurance & Timescales for improvement

- In place for most Trusts with local actions agreed to maintain performance
- All Trusts to action during September
- In place for most Trusts with local actions to accurately reflect staffing demand
- In place across all Trusts through vacancy reduction action plans
- All Trusts to monitor and action locally as required

Metric: **Establishment & Staffing**
 CQC Domain: **Well Led**
 Month: **July 2022**
 Target: **n/a**



Metric: **Establishment & Staffing**
CQC Domain: *Well Led*
Month: **July 2022**
Target: **n/a**



Equality, Diversity & Inclusion

Acute Provider Collaborative Summary:

- Collective metrics are currently being developed for Equality, Diversity & Inclusion and will be reported to the Acute Care Board in the coming months. The following updates are for each of the Collaborative Trusts;

Chelsea & Westminster - Key highlights for July include working with our Staff networks and engaging staff with London Pride. We have expressions of interest for our BAME network chair and will be confirming the new chair soon. The network leads video sessions have been planned and this will be finished once the new network chair is in place. We have the new Summary EDI report that will be presented at PPEEG in August. We are working on all of our national reports for WRES, WDES, GPG and our Annual EDI report

Hillingdon - The EDI Lead ran 7 Diversity and Inclusion workshops for teams and departments, where 81 colleagues attended in total. Regular walkabouts and drop in sessions continue as planned and there have been initial discussions with FTSU and H&W leads for collaborative work. We held a Reciprocal mentoring debrief meeting and our Trust attended the PRIDE London parade on the 2nd July. July saw the launch of the International Nurses Network and a 'Let's Talk' event: Micro aggression, was held

Imperial - In September 2021, the Trust launched a new inclusive recruitment approach to be implemented for all appointments at a band 7 and above. The approach required line managers to do two things; to ensure they have a diverse panel (gender and ethnicity) and to write an outcome letter to the Chief Executive, providing details of their shortlisted candidates, outlining their selection process and providing rationale for the hiring decision made.

Between September 2021 and March 2022, 412 campaigns for new band 7 or above leaders have been advertised, shortlisted and a hiring decision made. There have been 375 offers of employment with 65% of applicants, 52% of shortlisted applicants and 44% of the successful candidates are leaders from a black, Asian or minority ethnic background. Work continues to embed this process and track progress for impact and outcome. The monthly data has been added to the directorate and divisional scorecards to support embedding the inclusive recruitment programme across the Trust

London North West - An Independent Staff Insight Group was set up to support diversity and inclusion: the terms of reference have been agreed. This group has commissioned a piece of work to look at the proportion of black ethnic and minority groups at different grades in the Trust. The WRES and WDES return has been completed and an action plan will be developed to address key issues.

Employee Relations

Acute Provider Collaborative Summary:

- Collective metrics are currently being developed for Employee Relations and will be reported to the Acute Care Board in the coming months. The following updates are for each of the Collaborative Trusts;

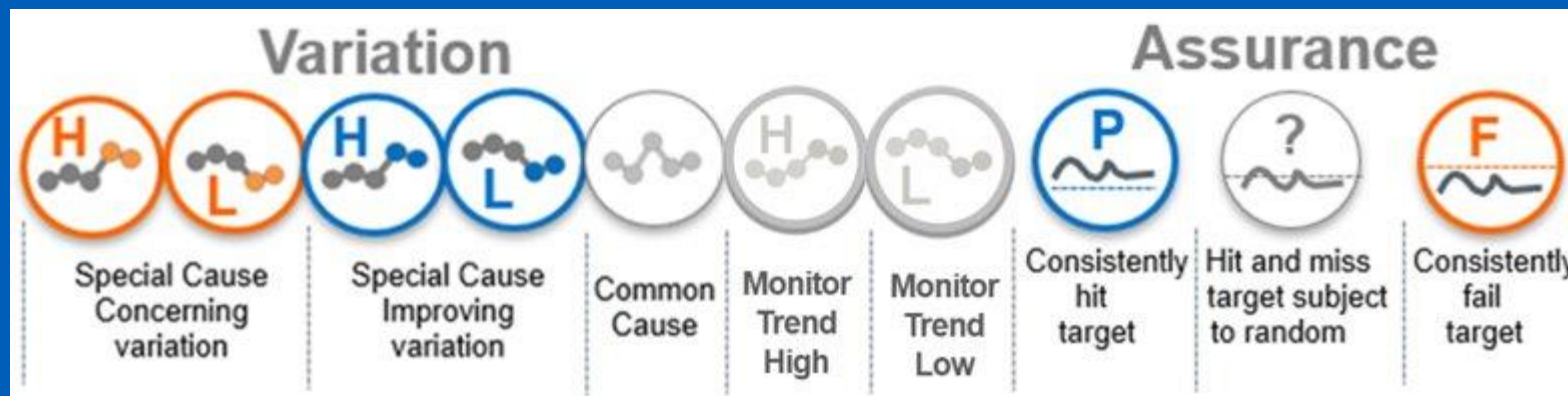
Chelsea & Westminster – Employment Relation cases are low at formal stages with three disciplinary cases and eight grievances. Formal cases remain low due to focussed informal and alternative resolutions, and in turn, an increase of informal resolution cases. Employment Tribunal cases have further reduced from six to five

Hillingdon - The Employee Relations team had 17 cases in July (seven conduct cases, four DAW cases, two grievance cases, four informal fact finds. The number of cases remain steady, however there remain some complex and time consuming ER cases within this number. There continues to be an increase in grievance and Dignity at Work concerns raised, however the fact finding stage is reducing the number of formal cases and the timeframes for resolving concerns. The ER team have been focusing on a very complex SARs request that was a priority and continue to deliver monthly training on HR policies

Imperial – We are continuing to see the number of formal disciplinary hearings reduce with more misconduct being managed informally, we currently have eleven cases categorised as disciplinary. We also have ten grievances and again, since introducing our new resolution approach, we are starting to the number of formal cases reduce. Over 60% of our Employee Relation cases are linked to long term and high levels of sickness absence

London North West - The introduction of a disciplinary checklist prior to starting formal disciplinary cases has reduced the number of cases being managed. A new tracking system has been introduced to monitor cases. MHPS cases are closely managed with input from our lawyers and medical director on a regular basis

Notes: SPC charts - Key



Further information on Making Data Count
<https://www.england.nhs.uk/publication/making-data-count/>



4.1 Report from Collaborative Finance and Performance Committee Chair

Discussion Item Speaker: Committee Chair and CEO Lead Catherine Jervis / Lesley Watts Time: 10.15

- Month 5 Financial Report

References:

- Enc 07 - 10. Collaborative Committee Covernote.pdf
- Enc 07 a. Chairs Report Collaborative F&PC_Final.pdf
- Enc 07 b i. CoverSheet Finance Report Month 5.pdf
- Enc 07b ii. NWL Acute Programme Board -M5 Financial Performance final V2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
18/10/2022
Item number: 4.0- 4.4
This report is: Public

North West London Acute Provider Collaborative – Highlight Report from Collaborative Committees

Author: Dawn Clift
Job title: Programme Director, NWL Acute Provider Collaborative

Accountable director: Steve Gill, Catherine Jervis, Janet Rubin, Bob Alexander
Job title: Chairs of Collaborative Committees

Purpose of report

Purpose: Assurance

The Board in Common is requested to receive assurance that all Collaborative Committees have met during September 2022 to:-

- Oversee and receive assurance that the Trust level Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- Oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- Identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
- Draw to the Board in Common’s attention matters they need to agree, or note

Report history

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

N/A

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Executive summary and key messages

All Collaborative Committees have met during September 2022. Each Collaborative Committee has reviewed its Terms of Reference and is recommending approval to the Board in Common.

The following Collaborative Committees have reviewed metrics and key performance indicators relating to their specific aspect of governance at local Trust level and collaborative level:-

- Quality
- Finance and Performance
- People

All Collaborative Committees continue to develop their metrics to ensure standardisation and commonalities in reporting and measurement across the Collaborative.

All Collaborative Committees have reviewed risks relevant to their area of governance.

All Collaborative Committees have commenced a review of key priorities for Committee to govern

With regard to quality, the Collaborative Quality Committee received assurance that all four trusts are on track to achieve full compliance against all 10 safety actions detailed in the CNST Maternity Scheme but acknowledged that there were operational risks which could occur during the winter which could potentially impact delivery. In addition, the Committee noted that during July, August and September all Trusts have had an assurance visit by the NHS London regional team to provide assurance against the 7 immediate and essential actions (IEAs) from the interim Ockenden report (December 2020). They also reviewed progress against compliance with subsequent recommendations issued.

With regard to finance, the year to date deficit of £27.7M against a plan of £10M deficit was scrutinised with causal factors noted as ERF recovery, CIP delivery and in year cost pressures. Work continues to identify an appropriate forecasting and reporting approach plus the identification and deployment of appropriate affordable actions to improve delivery of the financial plan.

With regard to People, a number of workforce metrics are under considerable pressure including increasing levels of sickness absence. The past 12 months has seen an increase in the rolling sickness absence rate which is at 4.8%. This is a special cause concern.

With regard to the Infrastructure and Capital Committee, a review of the Strategic Collaborative Estate Context took place at the meeting, along with a review of the Collaborative's Digital Strategy.

Strategic priorities

Tick all that apply

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

Click to describe impact

Impact assessment

Tick all that apply

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

Reason for private submission

Tick all that apply

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

If other, explain why

North West London Acute Provider Collaborative Collaborative Finance & Performance Committee Chair's Highlight Report to the Board in Common – for discussion 18 October 2022

Highlight Report of the meeting held on 20 September 2022

1. Purpose and Introduction

The purpose of this report is to provide the Board in Common with assurance of the work undertaken by the Collaborative Finance & Performance Committee at its last quarterly meeting on 20 September 2022 and to provide any feedback to it and to request if it requires further work to be done within the Committee's remit.

The role of the Collaborative Committee is:-

- To oversee and receive assurance that the Trust level Finance and Performance Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements.
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements.
- To draw to the Board in Common's attention matters they need to agree, or note.

2. Key Highlights

2.1 Positive Assurances Received

- Trust processes in place to monitor and report key performance metrics and escalations to the FPC CiC
- Performance reports for the FPC CiC enabled scrutiny for key metrics and will be further developed for future CiCs
- There is good performance against key waiting list targets 104 and 74 week waits
- Evidence will be shown in reports about how treatment and process is benefitting those patients from most deprived communities. This will need to be worked on by all Trusts.
- The Committee was assured that mutual aid processes are established and working effectively and were provided with an example of how this was working in relation to challenged diagnostic services.
- The UEC Board for North West London met monthly in London and walk throughs were performed regarding ambulance handovers. Walk throughs of mental health pathways had also taken place and acute Trusts had performed self-assessments in order to share best practice, to better manage flows and to identify improvements. Trusts had also considered how to share and standardise professional processes and to learn from one another.
- Each Trust had its own Winter Plan being approved by each Trust.

2.2 Key Risks to Escalate

- Discharge to Assess had been discontinued by Local Authorities which will have an impact on discharge into the Community. The ICS will need to see whether money can be released to Local Authorities to manage assessments outside of hospitals.
- Year to date deficit - At month 4, the Collaborative is reporting a year to date deficit of £27.7m against a plan of £10m deficit - a £17.7m adverse variance. The key drivers of adverse financial performance were in respect of ERF Recovery, CIP delivery and in-year cost pressures across the four Trusts.
- ERF performance - £8.7m of the adverse performance is 'lost' ERF in aggregate, with a shortfall in recovered income in three Trusts mitigated by over-recovery in ICHT. The ECB, plus Trust Recovery Groups, continues to support a steadily improving performance, but the overall income remains at risk. Trust CFOs are working closely with COOs, and with the ICB CFO on an appropriate forecast and reporting approach, plus affordable actions to improve delivery.

2.3 Concerns Outstanding

- There were plans for a super-September to improve the ERF performance but it was possible that it could be impacted by the unplanned bank holiday in September.
- Most trusts reported a challenged position against 52 week waits. The number of people waiting greater than 52 weeks on the RTT pathway remained stable overall until March 2022. The number of patients waiting >52 weeks is significantly above target and growing, and elective total activity is below the 107% of 19/20 activity target.
- The recent BMA rate-card guidance for consultants could impact anaesthetic staff and hinder elective recovery.
- If the winter funding is not forthcoming it will create a risk across the system as a whole.

2.4 Key Actions Commissioned

- The CFOs were asked to consider what areas and programmes needed to be developed and to report back at the next meeting.
- The Collaborative's risk and areas of future deep dives would be provided at the December meeting.

2.5 Decisions Made

- The Committee approved the adoption of the Terms of Reference.
- Capital business cases would be considered by the Infrastructure and Digital Collaborative Committee and the Finance and Performance Collaborative Committee would be responsible for approving the business case.
- It was agreed that peer review of services by clinical and operational leaders would be used to encourage the spread of operational best practice and the identification of where Trusts need capital, workforce or process change support to move to best practice

3. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Adoption of Terms of Reference	Approval	9.	Collaborative Strategic change programmes	Noting
2.	Integrated Quality & Performance Report	Noting	10.	Collaborative Financial & Performance Risks and Assurance	Noting
3.	Winter Plan	Noting	11.	Trust Level Committee Assurance Reports	Noting
4.	Urgent Treatment Centres	Noting	12.	Forward Agenda Planner	Noting
5.	Elective Diagnostics	Noting	13.	Key issues for the Board in Common	Noting
6.	Elective Activity / Waiting Lists	Noting			
7.	Finance Report & CIP delivery	Noting			
8.	Financial Recovery Report	Noting			

4. 2022 / 23 Attendance Matrix

	Attended	Apologies & Deputy Sent	Apologies
Members			
Catherine Jervis, (Chair)	✓		
Nilkunj Dodhia	✓		
Bob Alexander	✓		
David Moss	✓		
Lesley Watts	✓		
Matthew Swindells, Chair	✓		
Jon Bell	✓		
Tina Benson		✓	
Rob Hodgkiss	✓		
Virginia Massaro	✓		
Claire Hook	✓		
Jazz Thind	✓		
James Walters	✓		
Jonathan Reid	✓		
Peter Jenkinson	✓		
Daryl Lutchmaya	✓		

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 4.1

This report is: Public

Finance Report – Month 5

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

Accountable director: Jonathan Reid, on behalf of the NWL Acute CFO Group
Job title: Chief Financial Officer, London North West University Healthcare

Purpose of report

Purpose: Assurance

The Committee is asked to note the Month 5 financial position across the collaborative and the work in hand across the CFO group to support improved delivery against the financial plan.

Report history

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

Acute CFO Group 07/10/2022 Agreed by the Acute CFOs	Trust Finance & Performance Committees Various dates Noted	Committee name Click or tap to enter a date. What was the outcome?
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Executive summary and key messages

This brief report provides an update to the Collaborative Committee on in-year delivery of the financial plan to month 5. The Trusts are working individually and collectively on a forecast for the full year, and are discussing key options with the ICB CFO as well as with Trust Boards. The paper sets out the challenges emerging in the in-year financial position, noting that the key drivers of adverse financial performance are in respect of ERF Recovery, CIP delivery and in-year cost pressures across the four Trusts. Collectively, the Trusts are adverse to plan by £26.6m, and focused action is required (and in hand) in respect of strengthening delivery against the ERF requirements and the CIP ask for the Trusts. The report sets out key actions in hand across the Trusts to support improved delivery against the financial plan. The report also

notes the strong cash position, and progress against the capital plan – noting that year to date delays are anticipated to be recovered across the balance of the financial year. The report also notes that significant external capital funding has been secured to the Collaborative, and notes that the CFOs are carefully tracking receipt and spend to mitigate any risk of underspend.

Strategic priorities

Tick all that apply

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

Delivery of our financial plan will support achievement of our strategic priority, and will provide resources to support delivery of each of the other priorities.

Impact assessment

Tick all that apply

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

Click to describe impact

Reason for private submission

Tick all that apply

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

If other, explain why

NWL Acute Provider Collaborative Month 5 Finance Update

Helen Berry, Asst Director of Finance, supporting the Acute Collaborative
Jonathan Reid, CFO LNWH, on behalf of Acute CFO Group

Executive Summary

Financial Performance

At month 5, the Collaborative is reporting a year to date deficit of £38.5m against a plan of £11.8m deficit - a £26.6m adverse variance. In the month, the Collaborative reports a £9m adverse variance plan. All four trusts report YTD adverse variances to plan. The drivers remain as per previous months :

Elective Recovery Funding (ERF): £11.7m of the adverse performance is 'lost' ERF in aggregate, with a shortfall in recovered income in three Trusts mitigated by over-recovery in ICHT. The ECB, plus Trust Recovery Groups, continues to support a steadily improving performance, but the overall income remains at risk. Trust CFOs are working closely with COOs, and with the ICB CFO on an appropriate forecast and reporting approach, plus affordable actions to improve delivery.

Cost Improvement Programmes (CIP): Trusts are adverse to plan on CIP by £16.5m against a plan of £36.4m and a proportion of the delivered CIP is through non-recurrent measures. This presents a material risk to the financial position. CFOs review the CIP and productivity programmes within their Trusts on a formal and regular basis, and the Collaborative is discussing ways in which trusts can work in a joint partnership approach on some initiatives and schemes to strengthen the delivery. To note the NWL ICB Financial Recovery Board is also reviewing delivery, and the ICB CFO has proposed a number of interventions across the ICB, including agency spend targets.

Inflation and Operational Pressures: Trusts are still working through and calibrating the financial pressures arising from inflation driven by CPI, as well as the additional costs of increased staff sickness, and increased demand pressures. These are, however, material, and the CFOs are reviewing key elements of this expenditure to support actions to mitigate where possible. However, there is a risk that these costs cannot be fully mitigated within the current financial envelopes.

Forecast: At month 5 trusts continue to report a forecast which meets the annual deficit plan of £5.6m. However trusts have undertaken a review of their forecasts at Month 5 which have been discussed with the ICB CFO. Forecasts are being finessed as a result of the discussions and are being further refined by trust finance teams. Updated and agreed revised forecasts will be presented to Trust Finance and Performance Committees ahead of the next Collaborative Finance & Performance Committee.

Collaborative Financial Performance to Month 5

NWL Acute Collaborative (Month 5 Financial Performance)

2022/23	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
Income	281,343	272,912	(8,431)	1,407,368	1,398,081	(9,287)	3,374,945	3,393,223	18,778
Pay	(169,921)	(173,726)	(3,805)	(850,605)	(865,709)	(15,104)	(2,029,588)	(2,036,050)	(6,962)
Non-Pay	(108,290)	(106,078)	2,212	(543,864)	(547,955)	(4,091)	(1,301,661)	(1,317,034)	(15,373)
Non Operating Items	(4,953)	(3,885)	1,068	(24,744)	(22,874)	1,870	(49,296)	(45,739)	3,557
Total	(1,821)	(10,777)	(8,956)	(11,845)	(38,457)	(26,612)	(5,600)	(5,600)	0

At Month 5, the Collaborative is £26.7m adverse to plan, with a significant adverse variance in pay (£15.1m) and income (£9.3m). The drivers of the adverse position continue to be undelivered CIP; inflationary pressures and under recovery of ERF. In addition operational pressures associated with emergency demand and responding to the elective recovery programme contribute to the overall adverse position.

In Month 5, the Collaborative reported an adverse variance against plan of £9m, mostly driven by income under plan and continued pressures on pay – including staff sickness and agency.

At Month 5, Trusts are forecasting no variance from submitted plans, Updated forecasts have been prepared and discussed with the ICB CFO. Refreshed forecasts will be reported next month following review and sign off by Trusts.

Collaborative Financial Performance to Month 5 by Trust

2022/23	In Month Plan £000	In Month Actuals £000	In Month variance £000	YTD Plan £000	YTD Actuals £000	YTD variance £000	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
THH	(1,366)	(2,833)	(1,467)	(10,159)	(12,630)	(2,471)	(5,600)	(5,600)	0
LNWH	(522)	(5,044)	(4,522)	(1,230)	(10,873)	(9,643)	0	0	0
CWFT	67	(217)	(284)	(456)	(1,852)	(1,396)	0	0	0
ICHT	0	(2,683)	(2,683)	0	(13,102)	(13,102)	0	0	0
Total	(1,821)	(10,777)	(8,956)	(11,845)	(38,457)	(26,612)	(5,600)	(5,600)	0

The position by Trust notes that all Trusts are reporting adverse year to date and in month variances to plan.

It is important to note that for three Trusts – THH, CWFT and ICHT, the month 5 reported positions are largely based on Month 4 forecasts, using best available information. This due to a system outage caused by a cyber attack at Advanced, which run the e-financials general ledger platforms at all Trusts. It is likely that additional adjustments will need to be made in month 6 as more data becomes available.

Acute Collaborative Trust Summary narrative

ICHT:

The Trust is reporting a £13m deficit against a break even plan year to date with key drivers being: under delivery of the efficiency programme and overspends in ICU due to recruitment challenges. The ERF VWA activity calculation was above 104% and therefore attracted additional income of c£3.4m.

The Executive Transformation meeting in September agreed a set of mitigations that support the delivery of the financial plan which seek to deal with the current under delivery of CIP plans and costs associated with operational pressures . These will be reflected in the monthly forecast outturn refresh process

LNWH:

At month 5 the trends identified in earlier months continue, notably challenges on ERF and CIP delivery. The Trust reported an adverse movement in the month, reflecting both a decision to cease deployment of any non-recurrent support and a refreshed position on high cost drugs charging. This is not expected to continue as the run-rate into future months. The Trust forecast was refreshed during September, and a detailed Divisional review process is underway led by the CFO. The Trust is seeking to agree control totals with Divisional teams for the latter half of the financial year, including the deployment of winter resources, to support an improved exit run-rate.

During September, the Trust completed the “HFMA Financial Sustainability” self-assessment toolkit and have developed an action plan to address key issues identified. The Trust’s internal auditors have been commissioned to review the Trust’s self-assessment, and to support the CFO review of the overarching Grip and Control Framework. Results will be reported to the Trust Finance and Performance Committee at its next meeting.

CWHFT:

The Trust is reporting a £0.2m deficit in month 5 (£0.3m behind plan) and a £1.8m deficit year to date (£1.4m adverse variance). The key drivers continue to be under recovery of ERF (the floor of 25% of the total income has been assumed), CIP slippage and underperformance and inflation.

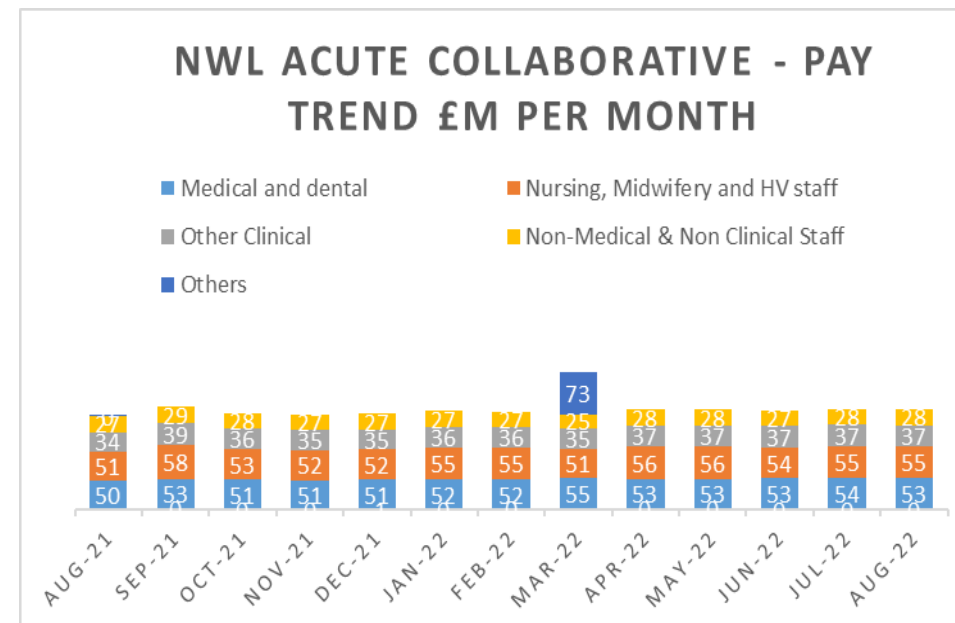
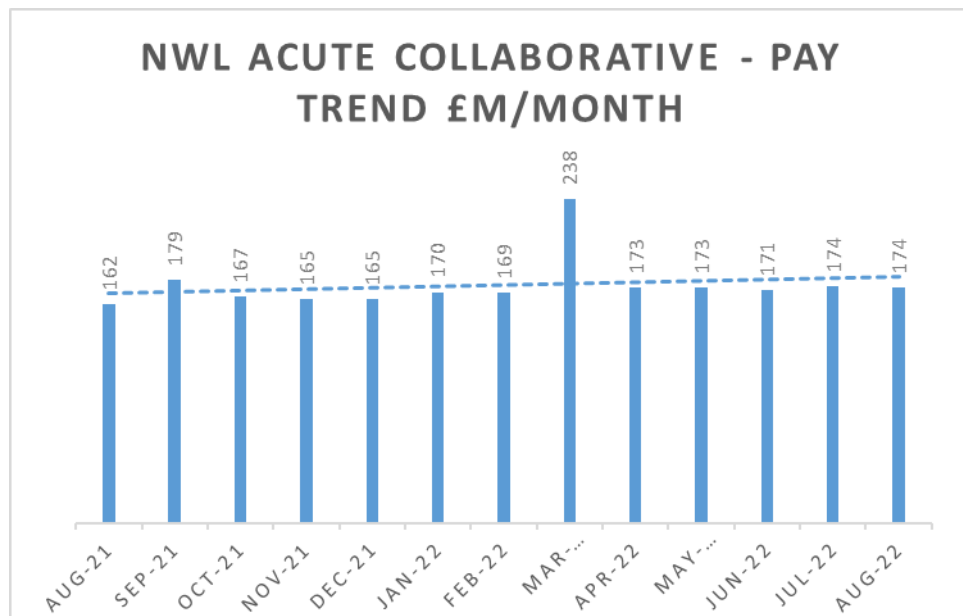
The Trust is forecasting to recover the year-to-date position to achieve its breakeven plan. A grip and control framework and additional pay and non-pay controls have been put in place to address the increase in run rate. Strengthened governance arrangements for divisions adverse to plan and a refreshed PMO approach are also in place to address the gap on the Cost Improvement Programme.

THH:

The Trust is reporting a £12.6m deficit against a £10.1m deficit plan at the end of month 5, a £2.4 adverse variance. The key drivers of the deficit continue and are: under delivery of the CIP programme and the under delivery of ERF. The targets for both of these increase during the year hence increasing the challenge in the second half of the year.

Following the CEO led intensive recovery reviews held in August and September with divisions, the Trust has refreshed it’s forecast; and this will be presented Trust’s F&P committee in September. Grip and Control measures and financial governance continue in line with the Financial Performance Framework and the Recovery Support Programme. .

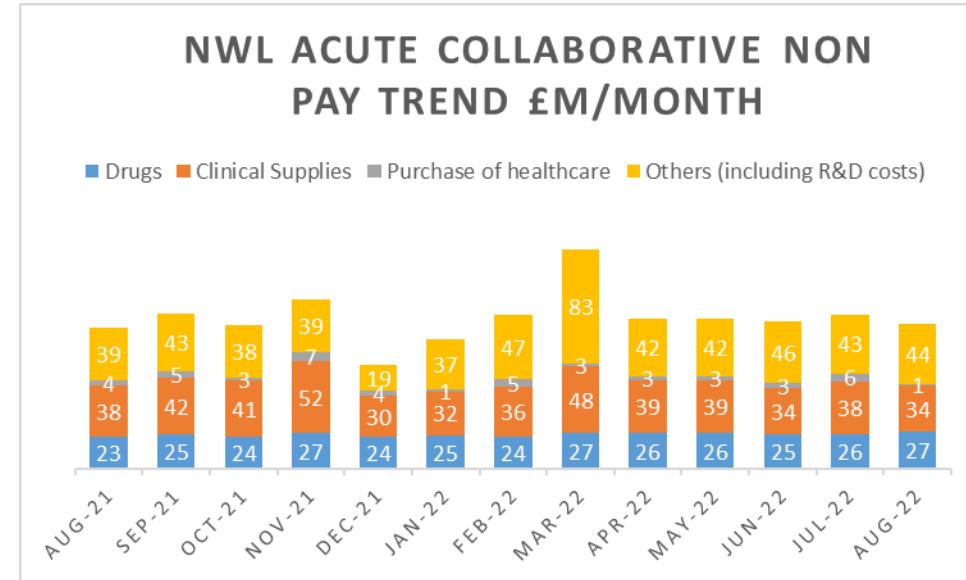
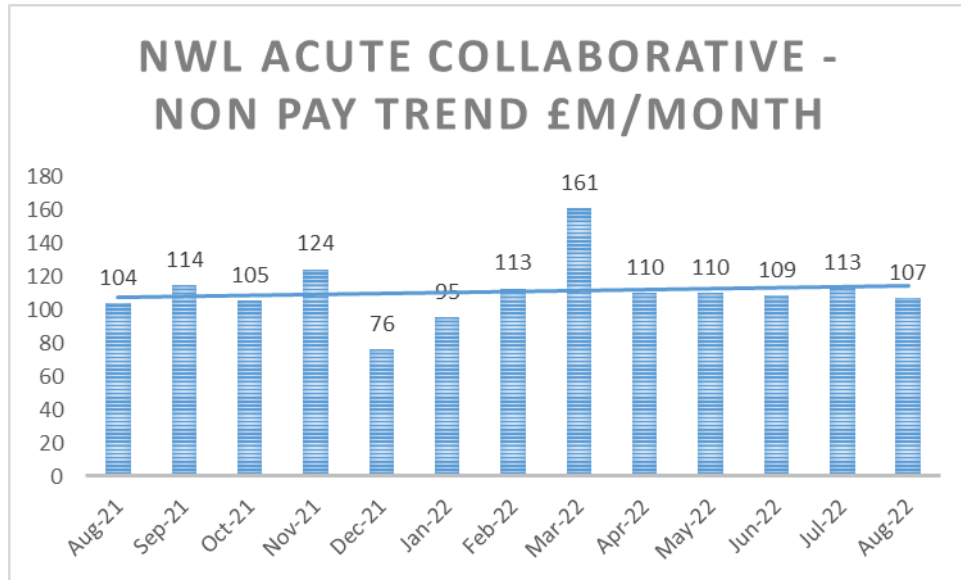
Collaborative Pay Run Rate to Month 5



The pay rate shown are absolute figures, not adjusted for covid or other underlying adjustments. The spike in March 22 represents accounting for additional employers NI costs (6.3%).

The average run rate has increased from £168m per month in 21/22 to £173m in 22/23 or 3%, this reflective of the Ni increase (c1%) and pay award (c2%) being accounted for in 22/23 ahead of payment (scheduled for month 6). The underlying pay spend per month is therefore unchanged.

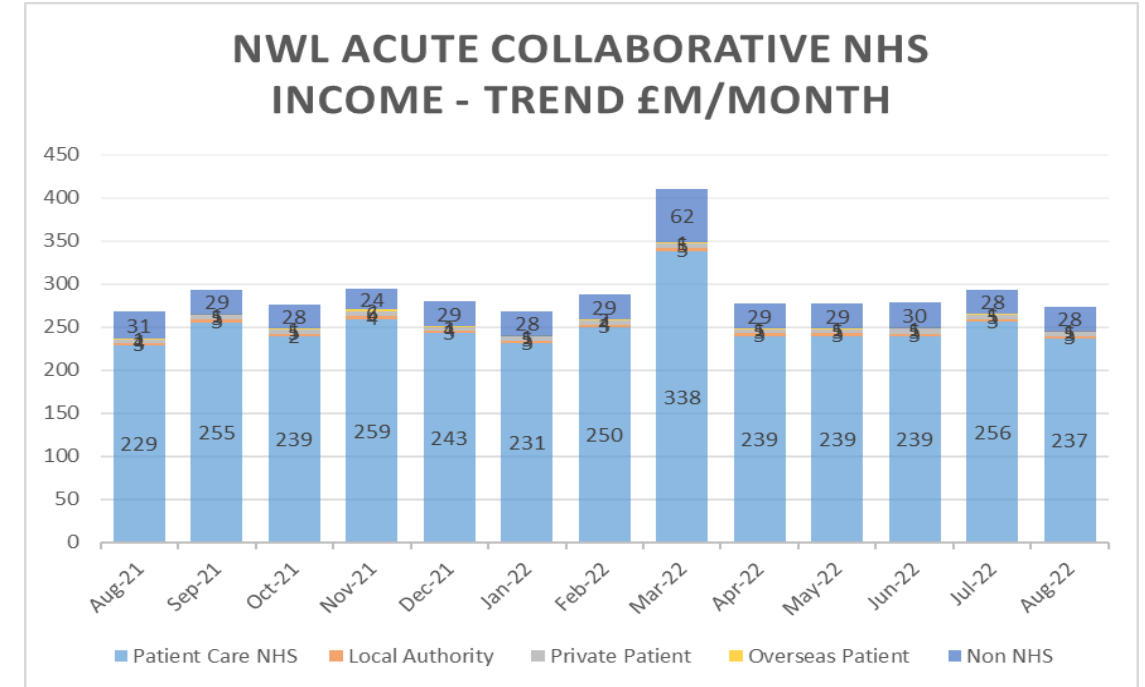
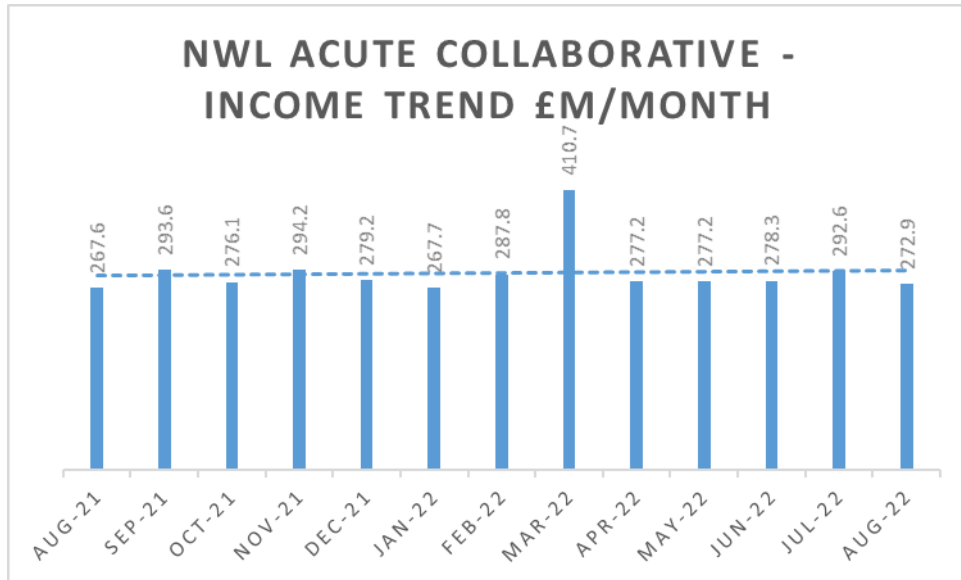
Collaborative Non Pay Run Rate to Month 4



The non pay run rate shown are absolute figures, not adjusted for covid or other underlying adjustments.

The average run rate has increased from £104.5m per month in 21/22 to £109.5m in 22/23. The run rate on clinical supplies and purchase of healthcare has fallen by 4% and 20% respectively, drugs spend has increased by 6% and other spend by 16% reflective of inflation on utilities and other contracts.

Collaborative Income Run Rate to Month 5



The income run rate shown are absolute figures, not adjusted for non recurrent income / underlying adjustments. The spike in month 12 reflects funding for the additional national insurance (6.3%).

The average run rate (excluding March 22) has decreased from £280.9m in 21/22 to £279.6m, -£1.26m or -0.5%.

Month 5 ERF Summary

A shortfall against the YTD plan is reported to month 5; resulting in clawback of ERF funding. However ICHT has exceeded the YTD target and has earned ERF in excess of the target.

The net impact to date on the Collaborative's financial position as a result of ERF clawback is a deficit of £11.7m. This breaks down across Trusts as : LNWH -6.4m, CWFT -£6.1m, THH - £2.6m and a surplus at ICHT of £3.5m.

The income plan includes ERF funding, earned when (cost weighted) elective activity (elective, day case, outpatient firsts and outpatient procedures) exceed 2019/20 level (plus 4% to reflect NHS aspirations to expedite recovery).

NWL ICS have applied a minimum income floor of 25% of the ERF YTD plan and this has been reflected in the year to date income at CWFT, THH & LNWH; therefore overall 25% of ERF income plan is accounted for at these three trusts. Continued elective activity delivery below the target puts this income source at risk..

Discussions are ongoing with the ICB CFO regarding the accounting of ERF funding in the first half of the financial year to support Trust positions.

ERF impact on I&E to month 5

	Ann Plan ERF £000	Plan to date £000	Actual to date £000	Variance £000
CWFT	19,621	8,175	2,044	(6,131)
ICHT	33,464	13,943	17,405	3,462
LNWH	19,751	8,230	1,800	(6,430)
THH	8,296	3,457	864	(2,593)
Total	81,132	33,805	22,113	(11,692)

To note:

- The YTD cost weighted activity will be updated to reflect activity that would have been uncounted the time of reporting. Thus month 4 and month 5 activity should increase once all activity is included.
- National guidance has been provided noting no clawback of ERF at a ICB level to month 5. NHSE London has instructed it's providers to report as above – providers report based on estimated actual performance with the equal and opposite surplus on ERF reported in the ICB position.

Month 5 CIP Summary

At Month 5, CIP delivery is under target by £16.5m for the Acute Collaborative. All trusts have supported their year to date delivery with non recurrent measures totalling £11m to date.

The overall forecast at month 5 is an under delivery against plan of £22m with £31m of non recurrent measures supporting this this position. CIP forecasts are being reviewed monthly in line with the overall forecast refinement.

The source of CIP performance is the monthly return reported to the ICB, which is consistent with the month 5 TFMS return reported to NHSE.

Actions to address CIP delivery going forward include:

- Further focus on CIP delivery at the Acute Collaborative Financial Delivery Board – to deep dive, report and review CIP performance of the sector, promote joint working.
- Acute Collaborative CIP and Transformation working group to be set up to facilitate CIP delivery across the sector.
- Agree a common methodology for ‘counting’ CIP across the collaborative to ensure consistency of reporting.
- CIP and Transformation governance in place at each trust with executive level management of CIP including CIP reporting, monitoring, identification and delivery.
- Grip and Control in place in all trusts to identify inefficiencies in processes and implement efficient solutions.

Efficiency - Month 5	YTD Plan £000	YTD Actuals £000	YTD variance £000	Annual Plan £000	Annual Forecast £000	Forecast Variance £000
CWFT	9,043	6,659	(2,384)	22,900	22,900	0
ICHT	15,417	2,723	(12,694)	37,000	20,156	(16,844)
LNWH	9,550	8,906	(644)	30,000	30,000	0
THH	2,400	1,622	(778)	12,000	6,900	(5,100)
Total	36,410	19,910	(16,500)	101,900	79,956	(21,944)
<u>Breakdown:</u>						
Recurrent	36,410	8,728	(27,682)	101,900	48,501	(53,399)
Non Recurrent	0	11,182	11,182	0	31,455	31,455
	36,410	19,910	(16,500)	101,900	79,956	(21,944)

Month 5 Capital Summary

At Month 5, the Acute Collaborative is reporting a £20.4m underspend against the year to date capital plan, with a current forecast overspend of £25.9m; greater than the notified CRL. However this position is not expected to result in a full year overspend as the plan will increase to reflect the funding due.

The forecast has moved from breakeven (in month 4). This is due to the approval by NHSE of major strategic projects under the national capital programme and targeted investment fund. These are the Elective Orthopaedic Centre, Community Diagnostic Hubs and supporting endoscopy capacity. These have impacted ICHT and LNWH's forecasts. THH is reporting an underspend due to a reprofile of the new hospital build capital budget. Revisions are agreed with NHSE.

The ICB has granted £6m additional capital to be used to fund collaborative schemes, which are being worked up and prioritised, these include equipment and assets to support Ophthalmology, and Diagnostics.

Capital	Year to date Month 5			Annual 22/23		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
CWFT	5,460	5,391	(69)	34,148	34,148	0
ICHT	23,798	21,035	2,763	72,998	105,858	(32,860)
LNWHT	9,446	4,729	4,717	31,638	57,396	(25,758)
THH	18,321	5,351	12,970	58,376	25,641	32,735
Total	57,025	36,506	20,381	197,160	223,043	(25,883)

Month 5 Cash Summary

The cash position of the collaborative is presented in the table.

Cash balances remain high compared to historic standards, reflective of top up income secured over the last two years to support the NHS in its response to the COVID pandemic.

To the end of August the cash balance has increased by £24.4m, reflective of capital approvals and broadly in line with organisations' cashflow plans.

Presently cash availability is not impeding decision making, especially regarding the collaborative's capital plans but this should not in itself be taken as an indication that organisations can continue to fund additional capital requests in the future as the need to maintain resilient liquidity is key.

The cash balance forecast at the end of the year reflects June's I&E plan submissions for the Trusts. To note this assumes delivery of CIP plans; capital expenditure and receipt of ERF funding.

NWL Acute Collaborative	March 31st 2022	Aug 31st 2022	March 31st 2023 forecast
Cash balance	£m	£m	£m
CWFT	158.3	170.9	149.4
ICHT	237.9	258.1	158.4
LNWH	70.4	83.1	35.4
THH	56.4	35.4	12.4
Total	523.1	547.5	355.5
Movement March - Aug		24.4	

4.2 Report from Collaborative Quality Committee Chair

Discussion Item Speaker: Committee Chair and CEO Lead Steve Gill / Tim Orchard
Time: 10.25

References:

- Enc 08. NWL Collaborative Quality Committee Report - October 2022.pdf

North West London Acute Provider Collaborative Collaborative Quality Committee Chair's Highlight Report to the Board in Common – for discussion October 2022

Highlight Report

1. Purpose and Introduction

The role of the Collaborative Committee is:-

- To oversee and receive assurance that the Trust level Quality Committees is functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
- To draw to the Board in Common's attention matters they need to agree, or note

2. Key Highlights

2.1 Review of Quality in the Acute Provider Collaborative

2.2.1 The Committee received the report which set out the agreed quality metrics, the first data dashboard and the priority work streams for the North West acute provider collaborative which included:

- Improving the care of deteriorating patients and those at the end of their life
- Reporting from and learning from Getting it Right First Time (GIRFT) and the Clinical Reference Groups
- Implementing the National Patient Safety Strategy
- Standardising reporting and improvement of maternity standards
- Learning and improvement from Mortality and Clinical Harm Reviews

2.2.2 The Committee noted that these quality metrics and priorities had been agreed following a detailed review of quality governance across the four Trusts in the acute provider collaborative. That review found a standardised governance approach with processes that align to CQC standards with clear priorities articulated and improvement plans in place. However there was variance across all Trusts in metrics reported, methodology of data measurement and limited commonality of priorities. Metrics and priorities were set using national guidance, areas of commonality and where opportunities for improvement and collaboration were clear.

- 2.2.3 The Committee received an update from each workstream lead setting out progress with scoping and planning of the projects. Detailed project plans will be in place for the next committee meeting which will set out best practice standards, outcome measures and goals being clear about the impact for, and experience of, service users and our teams. Short and long term benefits will be included to better inform the potential for improvement. The importance of being clear about the reason for the priorities being opportunities for the collaborative was agreed as well as setting out the responsibilities for each Trust.
- 2.2.4 An additional programme of work to set up a peer review process across the collaborative was confirmed. This will be further described for the next meeting.
- 2.2.5 The Committee noted the first draft of the quality metric dashboard, acknowledging that a number of core metrics had not yet been finalised and that the data had not been available for reporting through Trust quality committees. Variance was reported through individual Trust quality function reports with assurance received that they were known issues with actions and improvement plans in place.
- 2.2.6 Reporting arrangements were agreed and are set out in the forward planner for the committee. The metrics and priority workstreams will be key agenda items at this committee, a review of these will be undertaken by the executives and recommendations for collaborative work for 2023/24 presented to the March meeting. The Committee agreed three pillars of our quality improvement approach:
1. Transparent and comparable data across all four Trusts to inform quality improvement, risk identification and benchmarking.
 2. The adoption of evidence based best practice across our services, apply GIRFT and other evidence sources across the collaborative, not just individual Trust level.
 3. Clinical Peer Review where senior clinicians from all 4 Trusts will walk the core pathways for a service at all the locations it is delivered within the collaborative to:
 - identify improvement changes that can be made immediately
 - identify staff and skills changes that are needed over time to enable best practice
 - identify capital changes that are needed over time to enable best practice.

2.3 Clinical Negligence Scheme for Trusts (CNST) Submission

- 2.3.1 The Committee received the report noting that the maternity services in North West London were working towards full compliance of the Clinical Negligence Scheme for Trusts (CNST) 10 point plan. The Committee noted that progress of the CNST scheme was monitored monthly through the Local Maternity and Neonatal System (LMNS). It was noted that due to the impact of Covid-19, the scheme was paused from December 2021 – May 2022;

revised timeframes were published on 6 May with a requirement to demonstrate compliance with all 10 safety schemes by 2 February 2023.

- 2.3.2 The Committee were pleased to note that all four Trusts were on track to achieve full compliance against all 10 safety actions but acknowledged that there were operational risks which could occur during the winter which could potentially impact delivery. The Committee noted that the CNST report had not been presented locally at the four Trusts' Quality Committees prior to the Collaborative Quality Committee meeting and agreed that the Trusts would work further on the report to establish areas for information and assurance for the collaborative and areas to be managed locally by the individual Trusts.

2.4 Trust Quality – Function Reports

- 2.4.1 The Committee received quality performance reports from each Trust, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target. Assurance was gained about the work of each of the Trust's quality committees as well as reviewing the areas of variance.

- 2.4.2 Key risks highlighted by each Trust were noted as well as the common themes highlighted across all four reports which related to workforce, pressures in the emergency pathways, care of mental health patients in the emergency department, Ockenden inspections and CNST submissions. Assurance was gained that these were being managed within each Trust with detailed improvement plans for each. It was agreed that there were no risks or issues for escalation to the Board in Common, although noted common risks across Trusts in relation to workforce and the potential impact on quality from operational pressures and recommended that these risks are considered in collaboration with the other committees.

- 2.4.3 The Committee noted that the risk and assurance leads were working collaboratively to develop the risk management processes for the Board in Common and collaborative committees. This will set out how risks for the collaborative will be identified and reported to the Board in Common in future.

- 2.4.4 A standardised template for the quality function reports is now being agreed to align with the forward planner for this Committee.

2.5 Ockenden assurance reviews

- 2.5.1 During July, August and September all Trusts have had an assurance visit by the NHS London regional team. The purpose of these was to provide assurance against the 7 immediate and essential actions (IEAs) from the interim Ockenden report (December 2020). They also reviewed progress against compliance with subsequent recommendations issued.

- 2.5.2 Chelsea and Westminster NHS Foundation Trust (CWFT) have received a formal written feedback report which was reviewed at their Quality Committee on 4 October and confirmed compliance with all 7 IEAs.

- 2.5.3 The CWFT report makes comments on national issues related to recruitment, retention and risk of “burn out” of the midwifery workforce as well as the risk of data transfer between multiple handwritten and electronic systems. It also makes reference to the status of the action plan to achieve compliance with staffing recommendations from Birthrate+.
- 2.5.4 The reports from the other 3 Trust visits are in progress and will be reviewed by the Trust quality committees once received.
- 2.5.5 All 4 Trusts gave verbal updates at the committee with assurance gained that compliance will be achieved listing specific risks and mitigation plans.
- 2.5.6 The reports and actions from the visits will be reviewed through the quality function reports from each Trust at the next meeting.

2.6 North West London Collaborative Quality Committee Terms of Reference and forward planner

- 2.6.1 The Committee received and approved the North West London Quality Committee terms of reference - noting that, as a collaborative, the Trusts want to be demonstrably best in class in partnership working across health and care within the Integrated Care System and with other parts of the NHS, Local Authorities and the voluntary and private sectors; realising the benefits of mutual aid and working at scale of the populations and staff to deliver the highest quality of care efficiently, and supporting excellence in research and education.
- 2.6.2 The Committee also agreed an initial forward plan for the committee, noting the need to align the forward planners of Trust quality committees to feed into the collaborative level committee.

3. Assurances, risks and escalation to the Board in Common

- 3.1 Key risks highlighted by each Trust were noted as well as the common themes highlighted across all four reports which related to workforce, pressures in the emergency pathways, care of mental health patients in the emergency department, Ockenden inspections and CNST submissions.
- 3.2 Assurance was gained that these were being managed within each Trust with detailed improvement plans for each. It was agreed that there were no risks or issues for escalation to the Board in Common, although noted common risks across Trusts in relation to workforce and the potential impact on quality from operational pressures and recommended that these risks are considered in collaboration with the other committees.

4. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Review of quality in the acute provider collaborative			To note	9.	Actions and escalations			To note
2.	CNST submission			To agree	10.	Committee forward planner			To note
3.	Trust quality committee summary reports			To note	11.				
4.	Acute collaborative quality dashboard			To note	12.				
5.	Impact on quality of operational challenges – winter planning			To note	13.				
6.	Committee terms of reference			To agree	14.				
7.	Quality priorities 2022/23			To agree	15.				
8.	Key risks			To note					

5. 2022 / 23 Attendance Matrix

	Attended	Apologies & Deputy Sent	Apologies
Members			
Steve Gill, Vice chair (CWFT) (Chair)	✓		
Peter Goldsbrough, Non-executive director (ICHT)	✓		
Syed Mohinuddin, Non-executive director (LNWT)	✓		
Linda Burke, Non-executive director (THHT)	✓		
Tim Orchard, Chief executive (ICHT)	✓		
Julian Redhead, Medical director (ICHT)	✓		
Raymond Anakwe, Medical director (ICHT)	✓		
Roger Chinn, Medical director (CWFT)	✓		
Gubby Ayida, Medical director (THHT)	✓		
Jon Baker, Medical director (LNWT)	✓		
Melanie Van Limborgh, Chief nurse (THHT)	✓		
Robert Bleasdale, Chief nurse (CWFT)	✓		
Janice Sigsworth, Chief nurse (ICHT)			✓
Lisa Knight, Chief nurse (LNWT)		✓	
In attendance			
Matthew Swindells, Chair	✓		
Helen Hardy, Deputy chief nurse (LNWT)	✓		
Shona Maxwell, Chief of staff	✓		
Peter Jenkinson, Director of corporate governance	✓		

4.3 Report from Collaborative People Committee Chair

Discussion Item Speaker: Committee Chair and CEO Lead, Janet Rubin /Pippa Nightingale Time: 10.35

References:

- Enc 09. NWL Collaborative People Committee Highlight Report v3.pdf

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

September 2022

Highlight Report

1. Purpose and Introduction

The role of the Collaborative Committee is:-

- To oversee and receive assurance that the Trust level People Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- To identify, prioritise, oversee, and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
- To draw to the Board in Common's attention matters they need to agree, or note

2. Key Highlights

- 1) The Committee approved its Terms of Reference subject to additional wording in a number of the duties of the Committee to promoting a safe environment for collaborative staff in order to address the issues of bullying and harassment. The section on gender pay gap was also expanded to include ethnicity pay gap.
- 2) The seven overarching people priorities were discussed with a proposal to focus on three key/immediate priorities to be worked through by the NWL Acute Providers Chief People Officers and coordinated by the Chief Executive Lead.
- 3) 24 Workforce collaborative risks were considered, and it was agreed that a strategic and future-focussed collaborative workforce risk register will be developed ahead of the next meeting. Consideration was also given to workforce risk tolerance and appetite, and it was agreed that this would be discussed at the next meeting. The Committee recognised that there is a broader piece of work happening on risk management in the collaborative.
- 4) The Committee received the Acute Collaborative people metrics Dashboard which provided a clear view and high-level summary of the key people performance metrics across the Acute Provider Collaborative, providing context against the pressures and drivers, risks, and mitigations. The Acute Care Collaborative Chief People Officers are currently working on an agreed set of common targets for the core workforce metrics and will report against

these at the next meeting. The Committee recommended standardised KPIs for the Collaborative and high-level Collaborative actions.

- 5) The Committee received an update from the local provider People Committees with recommendations to standardise local forward planners in order for the Collaborative People Committee to have assurance that key topics are being discussed in a consistent manner; papers are written and formatted in a consistent manner to support benchmarking and onward reporting and that people priorities and underpinning people strategy People Priorities are aligned to ensure consistency in reporting and clear alignment with the NHS People Plan, Priorities, and the People Promise. These recommendations were accepted with the addition of a staff story to be incorporated in the agenda for all local provider people committees.
- 6) A summary of key data, issues and recommendations arising from the Workforce Race Equality Standard (WRES) report as at 31 March 2021 was noted by the Committee and is being published on 7 October on the four Trusts websites.

2.1 Positive Assurances Received

- Positive assurance that workforce risks are being identified across the Collaborative.
- Positive assurance that the annual WRES and DES data had been reviewed and approved at local people committees and will be published on local trust websites with local monitoring of improvement plans.

2.2 Key Risks to Escalate to the Board in Common

- 1) Increasing levels of sickness absence. The past 12 months has seen an increase in the rolling sickness absence rate which is at 4.8%. This is a special cause concern.
- 2) Increasing levels of voluntary turnover currently 13% for the past 6 months and a special cause variation.
- 3) vacancies at 11.4% with specific hard to recruit roles being a real challenge.
- 4) Trust and Collaborative preparedness and planning for winter.
- 5) Completion rate for both Non-Medical and Medical Performance Development Reviews and appraisals with no Trust meeting the target for both measures.
- 6) Collectively over-establishment by 268 Whole Time Equivalent (WTES)

2.3 Concerns Outstanding

Not applicable

2.4 Key Actions Commissioned

- Development of three immediate Collaborative People Priorities
- Strategic and future-focussed Collaborative risk register
- Standardised KPIs and targets for workforce performance and high-level Collaborative actions
- Standardised local forward planners in order for the Collaborative People Committee to have assurance that:
 - 1) assurance that key topics are being discussed in a consistent manner (short term 1-3 months)
 - 2) papers are written and formatted in a consistent manner to support benchmarking and onward reporting (medium term 1-6 months)
 - 3) People priorities and underpinning people strategy are aligned to ensure consistency in reporting and clear alignment
- A Collaborative Task and Finish Group should be established to review the 2022 WRES data and a suitable Collaborative action plan developed

2.5 Decisions Made

- 1) Agreed to recommend the amended Terms of Reference for approval at the Board in Common.
- 2) Approved the 7 overarching priorities of the Collaborative People Priorities and further requested 3 immediate priorities to be developed.

3. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome and apologies for absence			-	9.	Items to report to Board in Common			Information
2.	Conflict of interests			-	10.	Forward Planner			Verbal
3.	Terms of Reference			Approval	11.	Any Other Business			

4.	Acute Collaborative People Priorities			Approval	12.				
5.	Acute Collaborative People Risks			Discussion	13.				
6.	Acute Collaborative Dashboard			Discussion	14.				
7.	Local Provider People Committee Update			Discussion	15.				
8.	WRES assurance report			Information					

4. 2022 / 23 Attendance Matrix

	Attended	Apologies & Deputy Sent	Apologies
Members			
Janet Rubin, Non-Executive Director (Chair)	✓		
Sim Scavazza, Non-Executive Director	✓		
Simon Morris, Non-executive director	✓		
Ajay Meta, Non-executive director	✓		
Pippa Nightingale, Chief executive (LNWH)	✓		
In attendance			
Matthew Swindells, Chair in Common	✓		
David Searle, Director of Corporate Affairs	✓		
Sue Smith, Interim Chief People Officer (Chelwest & THH)	✓		
Tracey Connage, Chief People Officer, (LNWH)	✓		
Penny Parker, Associate Director, People Planning & Information (ICHT)	✓		
Phil Spivey, Deputy Chief People Officer (LNWH)	✓		
Sue Grange, Director of OD, Health and Wellbeing (ICHT) attended on behalf of Kevin Croft	✓		
Kevin Croft, Chief People Officer (ICHT)		✓	

4.4 Report from Collaborative Infrastructure and Capital Committee Chair

Discussion Item Speaker: Committee Chair and CEO Lead Bob Alexander / Patricia Wright Time: 10.45

References:

- Enc 10. NWL Collaborative Infrastructure and Capital Committee Highlight Report.pdf

North West London Acute Provider Collaborative Collaborative Infrastructure & Capital Committee Chair's Highlight Report to the Board in Common

Date of the meeting: 28 September 2022

Highlight Report

1. Key Highlights

The Committee received:-

Terms of reference

The terms of reference were discussed and approved subject to some amendments.

Members felt the committee should be a forum for bold thinking in generating collaborative opportunities in these strategic areas with an aggressive approach to their adoption and successful delivery and should, over time, ensure necessary engagement in the development of a capital prioritisation framework for the Collaborative, including principles for capital pooling where considered appropriate.

A review of the Strategic Collaborative Digital Context

The committee received a paper on the approach being taken to the development of the digital and data strategy for the individual organisations, the provider collaborative and the way in which this feeds into the digital and data strategy for the Integrated Care System. It highlighted the components of the ICS Digital Strategy which is in line with national thinking.

As part of this work on the digital and data strategy a set of digital and data priorities have been developed for the acute provider collaborative.

The focus of these priorities is on:

- Delivering improved clinician and patient experience while reducing costs
- Providing better tools to manage the flow of patients through our hospitals to support elective recovery
- Rationalising and increasing the resilience of our IT infrastructure

This then led to the development of the following set of digital priorities:

- Implementation and optimisation of the Cerner electronic patient record
- Improving patient flow and the use of capacity
- Patient empowerment and communication
- Resilience, rationalisation and standardisation
- Strategic reporting solution

The paper also summarised the key digital and data risks. It concluded with a summary of the next steps in the evolution and implementation of the digital and data strategy.

A review of the Strategic Collaborative Estate Context

The paper provided the Estates Strategies/Strategic context for The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust, and Chelsea and Westminster Hospital NHS Foundation Trust in order to provide a high level insight into Estate priorities, challenges, redevelopment initiatives etc. In addition the four Trusts outlined their top 3-5 Estates related risks.

Future work will focus on areas where collaboration will add value and reduce risk such as Water safety, Fire risk, Health and Safety. In addition, the committee expressed a desire to have a specific priority on Sustainability and the 'Green' agenda.

2. Positive Assurances Received

There were no positive assurances received.

3. Key Risks to Escalate

None.

4. Concerns Outstanding

None.

5. Key Actions Commissioned

None.

6. Decisions Made

- The framing of the committee to focus on a small number of bold issues in both Estates and Digital that will demonstrably add value.
- To update the Terms of Reference and forward plan to reflect the agreed focus and have these in place by the next meeting.

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome & Apologies				9.	THH – Redevelopment update			Information
2.	Declarations of Interest				10.	Forward Plan 2022/23			Information
3.	Matters Arising not covered by the rest of the agenda				11.	Key issues for the Board in Common			Information & Discussion
4.	Background to the Committee				12.				
5.	Committee terms of reference			Approval	13.				
6.	Strategic Collaborative Digital Context			Information & Discussion	14.				
7.	Strategic Collaborative Estate Context			Information & Discussion	15.				
8.	ICHT Summary Report: Redevelopment Committee – September 2022			Information					

8. 2022 / 23 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies
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Members:

Bob Alexander	Chair
Neville Manuel	Non-Executive Director
Aman Dalvi	Non-Executive Director
David Moss	Non-Executive Director
Patricia Wright	CEO Lead for the Collaborative I&C Committee
Jason Seez	Director of Strategy THHT
Dr Bob Klaber	Director of Strategy ICHT
Simon Crawford	Director of Strategy LNW
Virginia Massaro	Chief Financial Officer C&W & Collaborative CFO representative
Kevin Jarrold	Chief Information Officer
Hugh Gostling	Collaborative Director of Estates representative

5. Winter Plan 2022/23

Discussion Item Speaker: Claire Hook Time: 10.50

References:

- Enc 11. NWL Collab_winter planning_011022.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 5.1

This report is: Public

Planning for winter 2022/23

Author: Claire Hook
Job title: Chief Operating Officer, Imperial College Healthcare NHS Trust and
Chair of the NWL Urgent & Emergency Care Board

Accountable director: Claire Hook
Job title: Chief Operating Officer, Imperial College Healthcare NHS Trust and
Chair of the NWL Urgent & Emergency Care Board

Purpose of report

Purpose: Information or for noting only

The purpose of this paper is to update the Collaborative Board on progress with planning for winter 2022/23

Report history

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

Collaborative Finance & Performance Committee
20/09/2022
The Committee received and noted a verbal update

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

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

Executive summary and key messages

Demand for urgent and emergency care in NWL has increased above the 2019/20 baseline level and activity remains higher than normal for this time of year. In this context, we are preparing for a winter of further increasing demand and are working in partnership across the integrated care system (ICS) to ensure we are adequately prepared.

The ICS has identified £15.5m of additional funding for winter, £6.7m of this has been allocated to the acute trusts.

Capacity modelling indicates that implementation of our winter plans will largely mitigate expected demand at acute collaborative level in the “most-likely” scenario, but will not fully mitigate pressures on individual sites. It will therefore be essential to continue to work together to manage services and pathways in the most effective way possible.

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

1. Purpose

- 1.1. The purpose of this paper is to update the Acute Collaborative Board on progress with planning for winter 2022/23.

2. Context

- 2.1. The urgent and emergency care (UEC) system at a national level is under pressure. Demand for UEC services in NWL has increased above the 2019/20 baseline level and activity remains higher than normal for this time of year. In this context, we are preparing for a winter of further increasing demand and are working in partnership across the system to configure services and pathways in the most effective way possible.
- 2.2. In planning for a busy winter there is also an imperative to ensure we continue to provide timely treatment for cancer and urgent planned care patients, whilst reducing very long waits for other elective treatment.

3. National guidance

- 3.1. NHS England published its guidance for increasing capacity and operational resilience in urgent and emergency care ahead of winter in August 2022.
- 3.2. The guidance recognises that a lack of capacity across the NHS has an impact on all areas of the system and that, for hospitals, the root cause of the challenges seen at the front door, is often related to a lack of flow and delays with discharge. In view of this, NHS England has identified the following core objectives and key actions for operational resilience this winter:
 - Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
 - Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
 - Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
 - Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
 - Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
 - Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
 - Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
 - Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

3.3. Delivery of the core objectives will be measured at Integrated Care System (ICS) level through six metrics that NHS England has identified as key to the provision of safe and effective urgent and emergency care. These include:

- 111 call abandonment;
- Mean 999 call answering times;
- Category 2 ambulance response times;
- Average hours lost to ambulance handover delays per day;
- Adult general and acute bed occupancy; and
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

3.4. Each ICS was required to submit their plan to meet the core objectives, with corresponding performance trajectories for the six key metrics, at the end of September 2022. The expectation is that these trajectories will be delivered alongside existing Elective Recovery Plan requirements to eliminate waits of over 18 months and to reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023.

4. Performance trajectories

4.1. Three of the six key metrics relate directly to performance in acute hospitals. The system-level trajectories for these are shown in figures 1, 2 and 3. The trajectories are based on the collective impact of the interventions outlined in our winter plans and are underpinned by a set of assumptions about demand.

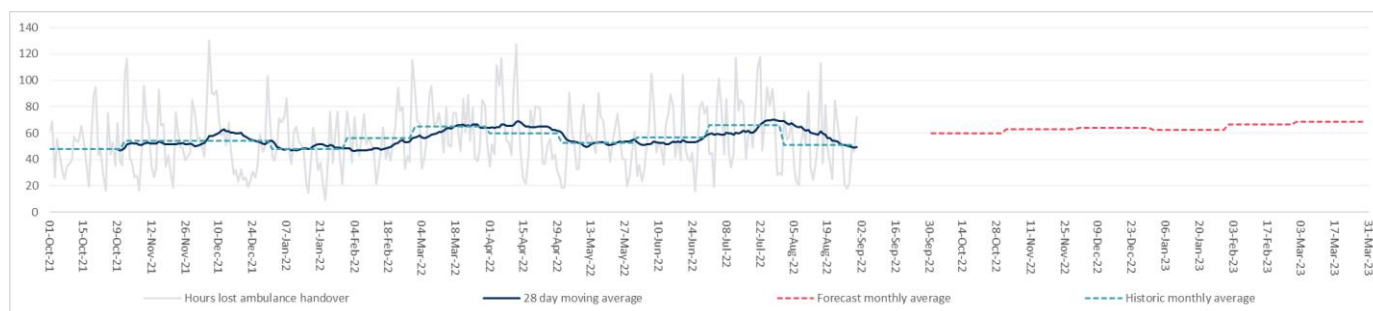


Figure 1: Average hours lost to ambulance handover delays per day

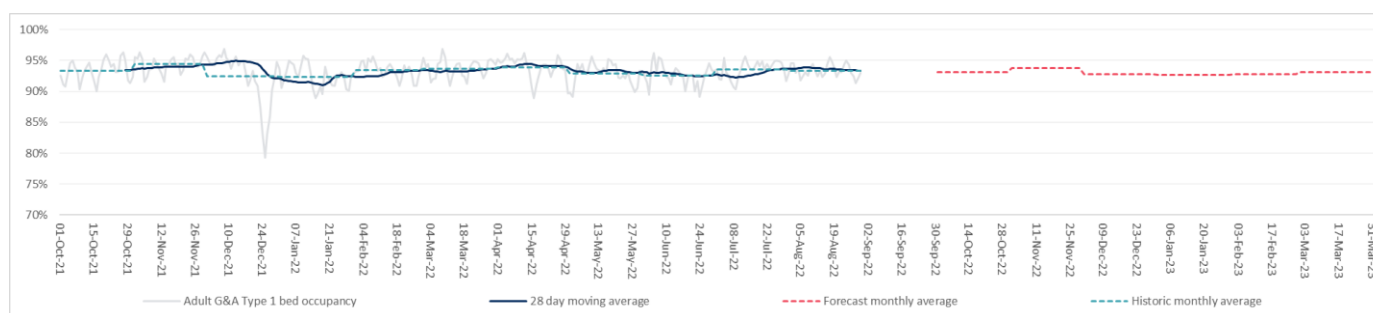


Figure 2: Percentage occupancy for adult general and acute beds

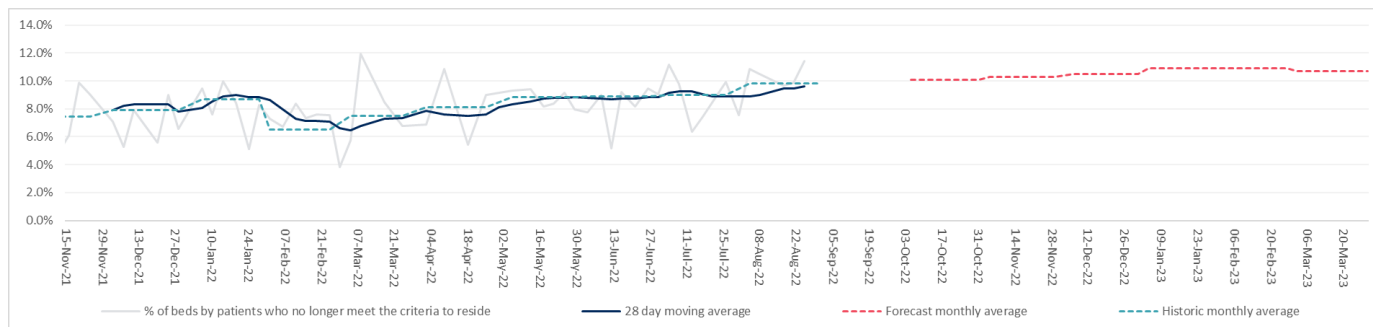


Figure 3: Percentage of beds occupied by patients who no longer meet the criteria to reside

5. Winter funding

5.1. The ICS has identified £15.5m of additional funding for winter, an increase from £12.5m last year. This includes a contribution from NHS England of £9.0m.

5.2. Proposals to use this funding were assessed using the following principles, which were agreed by the relevant programme SROs and programme directors across the ICS:

- I. There must be good evidence that the scheme will create capacity in acute hospitals to maximise elective activity and reduce ambulance handover delays;
- II. Schemes that support best use of existing capacity should be considered alongside proposals for additional beds and upstream community schemes to reduce demand; and
- III. Schemes must be deliverable at pace and benefit this winter.

5.3. As a result, a total of £6.7m has been allocated to the acute trusts, of which £5.4m relates to the opening of additional beds. The remaining funding will support expansion of Same Day Emergency Care (SDEC) services and other initiatives to support flow and discharge. Other funded schemes include beds in community and mental health settings, additional capacity in community mental health crisis teams, delivery of additional planned and unplanned GP slots at community locations in each borough and a patient and public communications campaign.

6. Developing our winter plans

6.1. To make optimum use of the available funding, and building on existing transformation work that supports improvement in managing flow all year round, the starting point for winter planning was a self-assessment and peer review process. The process was based on two key national documents that set out best clinical and operational practice for emergency departments and admitted patient care (Patient FIRST and FOCUSed). The assessment process was completed in collaboration across the acute trusts, with the findings presented to the NWL Urgent and Emergency Care Board in September 2022. A number of individual and system wide actions were identified as a result, which have now been incorporated into delivery plans.

6.2. In addition to opening additional bed capacity, the winter planning focus for all the NWL acute trusts continues to be ambulance handover, maximising the use of SDEC pathways and optimising discharge arrangements. Our plans incorporate the latest infection, prevention and control guidelines and we have made preparations should we see admissions for COVID, influenza and seasonal infections increase.

6.3. Capacity modelling indicates that implementation of our winter plans will largely mitigate expected demand at acute collaborative level in a “most-likely” demand scenario, but will

not fully mitigate pressures on individual sites. It will therefore be essential to continue to work together to manage services and pathways in the most effective way possible.

Ambulance handover

- 6.4. NWL receives the highest number of LAS conveyances in London and has the lowest waits. As a collective, we continue to prioritise reducing handover times, supporting timely transfer of patients into hospital care and freeing up ambulances to attend other emergency calls. All our trusts work closely with LAS, and each other, to minimise delays and to balance the conveyance load across our system.

Same Day Emergency Care (SDEC)

- 6.5. All our acute sites have well developed SDEC services, offering multidisciplinary (MDT) care to patients who don't require admission but need more time and specialist input than the emergency department can offer. The focus for winter is on extending the clinical pathways SDEC can provide. This includes establishing direct pathways from the LAS and primary care, along with ensuring that more people are streamed straight to SDEC from the front door.
- 6.6. Alongside SDEC, access to specialty services will be augmented with the expansion of hot clinics. These are one stop, rapid access specialty clinics that can be referred to directly by primary care clinicians and by inpatient teams to facilitate discharge.

Discharge

- 6.7. Efficient hospital flow is vital for urgent and emergency care pathways to work effectively. Over winter discharge processes will be supported by increased medical, therapy and pharmacy support, including focussing on more seven day delivery, with the goal of achieving discharge rates for pathway zero patients (where limited or no out-of-hospital support is required) that are more consistent with weekday rates.

7. Risks

- 7.1. There are a number of external factors that could increase the risk associated with managing a challenging winter period. These include:
- I. The risk to one or all of our hospitals in the event of demand rising above the "most-likely" scenario and/or increased COVID or respiratory illness;
 - II. Instability in the management of Urgent Treatment Centre (UTC) services – a standard specification for UTC services across NW London has been developed, underpinning a procurement process for those UTCs currently delivered by private sector providers that will put new contract arrangements in place for early 2023; and
 - III. Changes to arrangements for "discharge to assess" processes in local authorities that could increase waiting times for patients who are ready to leave hospital but require support on discharge.

8. Conclusion

- 8.1. It is anticipated that the winter of 2022/23 will be significantly challenging. Planning has incorporated a range of schemes that are designed to safeguard operational stability and maintain patient safety. Capacity modelling indicates that implementation of our winter plans will largely mitigate expected demand at acute collaborative level in the "most-likely" scenario, but will not fully mitigate pressures on individual sites. It will therefore be essential to continue to work together to manage services and pathways in the most effective way possible.

6. Reports from Trust Audit Committees

Discussion Item Speaker: Audit Chairs Time: 11.05

- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust

References:

- Enc 12 a Cover sheet - BiC ARC Chairs Highlight Reports - October 2022.pdf
- Enc 12 b. THHFT ARC Chairs Report - BiC October 2022.pdf
- Enc 12 c. CWFT ARC Chairs Report - BiC October 2022.pdf
- Enc 12 d. ICHT ARC Chairs Report - BiC October 2022 new version.pdf

NWL Acute Provider Collaborative Board in Common (Public)

18/10/2022

Item number: 6.0

This report is: Public

Audit and Risk Committee Chairs Report –

The Hillingdon Hospitals NHS FT

Author: Neville Manuel
Job title: Non-Executive Director

Accountable director: Neville Manuel
Job title: Non-Executive Director

Purpose of report

Purpose: Information or for noting only

The Board in Common is asked to note the report.

Report history

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

Chelsea and Westminster
NHS Foundation Trust
Audit and Risk Committee
28/07/2022
What was the outcome?

The Hillingdon Hospitals
NHS Foundation Trust
Audit and Risk Committee
12/09/2022
What was the outcome?

Imperial College
Healthcare NHS Trust
Audit and Risk Committee
14/09/2022
What was the outcome?

Executive summary and key messages

Attached are the highlight reports from the audit and risk committee meetings that have not previously been reported to trust boards:

- Chelsea and Westminster NHS Foundation Trust (28 July 2022)
- The Hillingdon Hospitals NHS Foundation Trust (12 September 2022)
- Imperial College Healthcare NHS Trust (14 September 2022)

The Board in Common is asked to note the key findings in each of the reports.

No items are escalated to the Board in Common from the individual Audit and Risk Committees.

The purpose of trust audit and risk committees is to provide the trust board of each trust with the assurance that adequate processes of corporate governance, risk management, audit and systems of internal control are in place and working effectively.

Each trust, as statutory organisations, are required to publish their respective annual report, financial accounts and quality accounts. They each have their own external and internal auditors to provide assurance on the effectiveness of the systems of internal control and the completeness, integrity and accuracy of the annual report and accounts.

Each of the trusts' audit and risk committees cover similar topics, although each trust's internal audit plan will be tailored to that trust's needs, including their risk profile and priorities. Common agenda items include:

- Report from the trust's external auditor
- Report from the trust's internal auditor
- Report from the trust's counter fraud specialist
- Review of losses and special payments
- Risk management, including review of key risks and board assurance framework

In addition, Committees have sought assurance regarding systems of internal control in specific areas, including cyber security arrangements.

Strategic priorities

Tick all that apply

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

[Click to describe impact](#)

Impact assessment

Tick all that apply

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

[Click to describe impact](#)

Reason for private submission

Tick all that apply

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

If other, explain why

North West London Acute Provider Collaborative The Hillingdon Hospitals NHS Foundation Trust Audit and Risk Committee Chair's Highlight Report to the Board in Common Date of Audit and Risk Committee: 12th September 2022

Highlight Report

1. Key Highlights

Finance

The committee noted:

- **Review of losses and special payments:** No write offs in quarter 1 of 2022-23 (Apr 2022 to Jun 2022).
- **Review of non-compliance with SFIs:** Overall trend continues downwards.
- **Debtors** - Aged debtor balances are £3.4m higher than the level at year end. Much of the balance relates to NHS bodies. The committee noted escalation underway to recover these debts.
- **Better Payment Practice Code (BPPC)** - The Trust has significantly reduced aged creditors. Balances have reduced from
- £19m to £5.1m between October 2021 and July 2022. BPPC performance has improved to 94% in July, compared with 71% in October 2021. The Trust has received a letter from Julian Kelly, CFO of NHS England, congratulating the Trust on improvements made.

Grip and Control

The committee received an update on the status of the Grip and Control initiative that forms part of the Recovery Support Plan (RSP)

Risk Management

The committee received a report from the Risk Management Group noting:

- Risk Management KPIs – Which demonstrated a steady balance of activity between corporate and divisional risk registers.
- Development and review of the Risk Management Strategy and Policy – noting work underway to streamline the policy and develop a summary risk strategy.
- Risk Management Training arrangements – taking assurance on arrangements to provide risk management training.
- Progress against the recommendations from the KPMG Strategic Risk Governance Review (June 2022) – noting actions are on track to be delivered through the revised Trust Policy and Strategy document.

- A Summary of work undertaken by the Risk Management Group between April and June 2022 – noting:
 - 9 new corporate risks added Jan 2022 – June 2022
 - 13 corporate risks reduced Jan 2022 – June 2022
 - 11 corporate risks closed Jan 2022 – June 2022

Board Assurance Framework

The Committee discussed the Board Assurance Framework (BAF), noting no change in risk scores and further development and refresh of the BAF once the Trusts overarching Strategy is finalised.

2. Positive Assurances Received

Internal Audit Programme 2022/23

The Internal Audit Programme for 2022/23 is progressing to plan, the first reports of the 2022/23 programme are on track to be received by the Committee in November 2022:

- HFMA financial governance
- Sickness Absence Management (Short-term)
- Quality Governance
- Waiting List Management incl. Data Quality
- Clinical Coding

The committee noted some improvement in closing Internal Audit recommendations, and to further strengthen accountability and management oversight that progress against recommendations and actions are now presented to the Trust Management Board.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

Counter Fraud

Following a review of the Counter Fraud Progress report and rising trends within the Trust and Nationally of employees working secondary employments whilst off sick. The committee have asked the Local Counter Fraud Service to incorporate some focused work in this area into their proactive work programme.

Risk Management

The Committee noted 'Inflation' referenced in the BAF Risk 3 (Finance), and agreed that this should be added as a separate risk to the Trusts Corporate Risk Register given significant and wide impacting concern in this area.

6. Decisions Made

Terms of Reference

The committee reviewed and approved its terms of reference in recognition of the establishment of the NWL Acute Provider Collaborative Governance arrangements and incorporating its reporting arrangements into the NWL Board in Common.

External Audit

The committee approved (subject to minor amendments) the Auditor's Annual Report 2021/22.

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	Welcome and Apologies for Absence			-	9.	Grip & Control Update			Assurance
2.	Declarations of interest			-	10.	Report from the Risk Management Group			Assurance
3.	Minutes of the meetings held on 25th April 2022			-	11.	Board Assurance Framework			Assurance
4.	Matters Arising and action log			-	12.	Terms of Reference			Approval
5.	Internal Audit Report			Assurance	13.				
6.	External Audit Report			Approval	14.				
7.	Counter Fraud Report			Assurance	15.				
8.	Finance Report			Assurance					

North West London Acute Provider Collaborative Chelsea & Westminster Hospital NHS Foundation Trust - Audit and Risk Committee

Chair's Highlight Report to the Board in Common – for discussion 18 October 2022

Highlight Report of the meeting held on 28 July 2022

1. Purpose and Introduction

The purpose of this report is to provide the Board in Common with assurance of the work undertaken by the Audit & Risk Committee at its last meeting on 28 July 2022.

The role of the Audit and Risk Committee is:-

- Review the establishment and maintenance of effective systems of internal control, establishment of value for money and risk management including fraud and corruption.
- Assure the Board on completeness and compliance of required disclosure statements and policies.
- Review the Trust's Annual Report, including Quality Report and financial statements, Annual Governance Statement and Head of Internal Audit Opinion and the External Assurance on the Trust's Quality Report and assure the Board on compliance.
- Assure the Board on judgements and adjustments relating to annual financial statements.
- Review the Trust's self-certification as required by NHS Improvement or its successors to comply with any conditions of its foundation trust licence.
- Assure the Board on the appropriateness and effectiveness of the internal audit service its fees, findings and co-ordination with external audit.
- Assure the Board on the appropriateness, effectiveness and co-ordination of external auditors, and the Trust's management response and outcomes.
- Assure the Board on the appropriateness and effectiveness of the local counter fraud specialist service, their fees, findings and co-ordination with internal audit and management.

- Make recommendations to the Council of Governors on the appointment, re-appointment and remuneration and terms of engagement of the external auditors.
- Assure the Board on the appropriateness and effectiveness of the Trust's Risk Assurance Framework and of the processes for its implementation.
- Ensure that arrangements are in place for investigation of matters raised, in confidence, by staff relating to matters of financial reporting and control, clinical quality, patient safety or other matters.
- Assure the Board on the appropriateness and effectiveness of the Trust's approach to mitigate and manage cyber security related risks.
- Undertake such other tasks as shall be delegated to it by the Board in order to provide the level of assurance the Board requires.
- Report to the Council of Governors on significant matters where these matters are not notified to the Council of Governors via other means.

2. Key Highlights

2.1 Positive Assurances Received

Internal Audit Progress

- The following 2021/22 reviews were in progress:
 - IT Architecture- fieldwork underway – this was slightly delayed due to staff turnover at BDO
 - Covid Restore & Recover- fieldwork underway
- The following 2022/23 reviews were in progress:
 - Safeguarding Adults- fieldwork underway
 - HFMA- Financial Sustainability
- The Committee noted ongoing reconciliation work with clinicians which the ABPI data had shown as having received a gift / hospitality with the Trust's own declaration of interests and liaison with those clinicians who hadn't made a declaration.
- The Committee reviewed the Patient Experience – Complaints audit which had received a moderate assurance on both design and operational effectiveness. The review had looked at the Trust complaints handling process, both informal and formal complaints and found that the Trust had robust policies and procedures in place, responded to complaints within agreed time frames in the in the main and that the divisions worked well. The audit had also benchmarked the Trust's policy and procedures against other Trusts and found that the time frames that it worked to were comparable with its peers.

External audit

- The external audit annual report and the audit certificate were both issued on the 7th of July. Everything was signed, issued and submitted externally. Overall, no significant weaknesses were identified in the Trust's value for money arrangements:
 - Financial sustainability – no significant weakness in the Trust's arrangements
 - Governance – no significant weakness in the Trust's arrangements
 - Improving economy, efficiency and effectiveness – no significant weakness in the Trust's arrangements

Counter fraud

- There was a significant increase in referrals received at the Trust with 18 having been received in 2021/22, compared to just seven the previous year which was a pleasing development and not concerning.

Risk and governance

- The Committee received a Cybersecurity report aimed at updating the Committee on the ongoing steps being taken by the Trust to mitigate and manage cyber security related risks and incidents. The update gave an overview of the main activities being undertaken to manage cyber risks, which were predominately focused on infrastructure and application remediation.

2.2 Key Risks to Escalate

- None

2.3 Concerns Outstanding

- Clarification about where future external governance or a CQC review / audit on Board Governance would be conducted - at a Trust or Collaborative level.

2.4 Key Actions Commissioned

- The fraud and bribery awareness programme would continue to be delivered throughout the year.

2.5 Decisions Made

- The following policies were approved:
 - Conflicts of Interest and Anti-Bribery Policy
 - Related Party Disclosure Agreement

3. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit 2022/23 Progress Report against Work Plan	Noting	9.	Cybersecurity Report	Noting
2.	Internal Audit Reports: Complaints	Noting	10.	Policies for approval - Conflicts of Interest and Anti-Bribery Policy - Related Party Disclosure Agreement	Approval
3.	External Audit Plan 2021/22 Annual Report & Certificate	Noting	11.	Losses and Special Payments including Write Offs	Noting
4.	Counter Fraud 2022/23 Annual Work Plan	Noting	12.	Waiver of SFIs	Noting
5.	Counter Fraud Progress Report	Noting	13.	Audit Committee Forward Plan	Noting
6.	Risk Assurance Framework - Risk Management Policy - Risk Appetite and Statement Review	Noting			
7.	Board Assurance Framework	Noting			
8.	National Cost Collection Board Assurance	Noting			

North West London Acute Provider Collaborative Imperial College Healthcare NHS Trust Audit and Risk Committee Chair's Highlight Report to the Board in Common Date of Audit and Risk Committee: 12th September 2022

Highlight Report

1. Key Highlights

External Audit

- 1.1 The Committee received the Auditor's Annual Report setting out the key findings arising from the audit carried out for the year ended 31 March 2022. This was previously noted by the committee in July 2022, however this now included commentary on the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources which are part of the Value for Money requirements.
- 1.2 The committee were assured that there had been no significant weaknesses identified in the Trust's Value for Money arrangements.
- 1.3 The committee also received the Independent auditor's certificate of completion of the audit which provided assurance that the audit team had completed all of their responsibilities in respect of the audit.

Year end audit - lessons learned review

- 1.6 The committee received the paper outlining the approach to be taken by management in relation to reviewing and understanding the factors that ultimately led to the Trust breaching the national deadline for submission of its 2021/22 annual accounts and report.
- 1.7 The committee noted that Trust Finance team and Deloitte audit team were working to collate a collective understanding of the issues that led to the breach. Findings will be brought to a meeting between the senior leadership teams for both organisations on 21st September 2022 and a deep dive will be carried out. This will be followed up with a further meeting on 26th September to work through a detailed execution plan to ensure that we are in a better position next year.
- 1.8 The committee will receive an update on this work at the next meeting in November 2022. If the committee are not assured following this work, then we will think about commissioning an independent review that will give further assurance. The committee approved the proposed approach.

Internal audit update

Internal audit progress report

- 1.9 The committee received the report providing an update on the internal audit plan 2022/2023, noting that a number of assignments have progressed from planning phase into the field work stage. The committee also noted the terms of reference for Improving NHS Financial Stability. The committee noted that the audit on risk management had been completed, providing an overall assurance rating of 'significant assurance with minor improvement opportunities'.

Counter fraud progress report

- 1.10 The Committee received the report outlining the progress of work against the annual plan. The committee noted that the targeted awareness programmes had been completed, and workshops would be taking place over the next month. The committee also noted that scoping had been carried out for the Cyber Security Review.

Risk and assurance report

- 1.11 The committee received the report on risk management and assurance at the Trust providing updates on the corporate risk register, the corporate risk profile and board assurance framework process. The committee noted recent risk and assurance deep dives surrounding existing corporate risk register risks or on emerging risks that had been completed. Deep dives for the November meeting had been agreed with each committee chair as part of the committee forward planner. The committee noted that there were no new emerging risks. All current concerns are already captured as part of the Corporate Risk Register.

Reports from Board sub-committees re risk and assurance deep dives and key risks

- 1.12 The committee received updates from the Board sub-committees with key highlights noted

ICS & NWL Acute Programme Risk Register

- 1.13 The committee noted that a review of the risk management processes across the North West London acute collaborative has begun. Risk leads from across the four trusts will meet in September to agree a joint approach with a first report being submitted to the joint board in common in October.

Annual Fire Safety Report including WEH Fire improvement notice update

- 1.14 The committee received a report as part of the Trust's annual fire safety compliance. The report confirmed that the fire safety team continues to provide expert advice to estates, projects, and training for staff to ensure fire safety compliance. A fire safety evacuation exercise is to be planned for 2022/23 to simulate a clinical ward evacuation.
- 1.15 The committee were assured that the Trust is currently compliant with its fire safety statutory obligations. The committee were also assured that all actions related to the Wester Eye Hospital Notice of Deficiency had been completed with London Fire Brigade being invited to site to review completed work.

Cyber Security Dashboard Deep Dive

- 1.16 The committee received a report providing an overview of the main activities currently being undertaken to manage cyber risks, which are predominately focused on infrastructure and application remediation. The committee noted the incident relating to a supplier to the Trust, "Advanced" being impacted by a cyber attack resulting in the loss of access to Trust systems hosted by Advanced including the finance system (e-Financials) and the Urgent Care System (Adastra).
- 1.17 The committee were informed that Business continuity procedures were invoked in both cases and the Trust was in the process of completing a risk assessment and controlled re-connection following an upgrade to assurances from NHS Digital. The committee noted that the Trust procured a number of cyber security enhancement solutions funded externally via public dividend capital. The cyber security and ICT operations teams were implementing, configuring and optimising these solutions.

- 1.18 The committee were assured that the Trust now operates 24/7/365 cyber security monitoring and response, supported through an external specialist 3rd party. This capability is strategically aligned across all 4 acute Trusts in the NWL ICB.

Losses and Compensation report

- 1.19 The committee noted the report confirming losses and special payments approved in the first quarter of the 2022/23 financial year.

Committee Forward Planner

- 1.20 The committee received the forward planner, noting that this would be refreshed once a chair is appointed.

2. Positive Assurances Received

External Audit

- 2.1 The Committee received the Auditor's Annual Report setting out the key findings arising from the audit carried out for the year ended 31 March 2022, including Value for Money conclusion. The committee were assured that there had been no significant weaknesses identified in the Trust's Value for Money arrangements. The committee also received the Independent auditor's certificate of completion of the audit which provided assurance that the audit team had completed all of their responsibilities in respect of the audit.

Internal audit progress report

- 2.2 The committee noted that the audit on risk management had been completed, providing an overall assurance rating of 'significant assurance with minor improvement opportunities'.

Annual Fire Safety Report including WEH Fire improvement notice update

- 2.3 The committee were assured that the Trust is currently compliant with its fire safety statutory obligations. The committee were also assured that all actions related to the Wester Eye Hospital NoD had been completed with London Fire Brigade being invited to site to review completed work.

Cyber security

- 2.4 The committee were assured that the Trust now operates 24/7/365 cyber security monitoring and response, supported through an external specialist 3rd party. This capability is strategically aligned across all 4 acute Trusts in the NWL ICB.

3. Key Risks to Escalate

None

4. Concerns Outstanding

None

5. Key Actions Commissioned

None

6. Decisions Made

Revised Terms of Reference

- 6.1 The committee agreed the revised Terms of Reference, noting the amendments made in the context of the establishment of the acute provider collaborative. As part of a standardised approach across the collaborative, it was highlighted that the committee would meet on a quarterly basis going forward.
- 6.2 The committee noted that it had previously had oversight of Trust Board sub-committees to ensure that risks are being managed and assurances are being provided at that committee level; however, with the changes made to memberships across the collaborative, a standard approach would be required to ensure we continue to obtain feedback / outputs from these committees.

7. Summary Agenda

No.	Agenda Item	Strategic Risk Mapping		Purpose	No.	Agenda Item	Strategic Risk Mapping		Purpose
		No.	Risk				No.	Risk	
1.	External Audit Report			To note	9.	Annual fire safety report & WEH fire notice			Assurance
2.	Year end audit lessons review			To note	10.	Cyber security dashboard			Assurance
3.	Internal Audit progress report			To note	11.	Losses and compensation			To note
4.	Counter fraud progress report			To note	12.	Committee forward planner			
5.	Terms of reference			Approval	13.				
6.	Risk and assurance report			To note	14.				
7.	Reports from board sub-committees			To note	15.				
8.	Acute programme risk			To note					

7. Any Other Business

Time: 11.20

8. Questions from Members of the Public

Time: 11.20

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.

9. Close of the Meeting

Time: 11.30

10. Date and Time of the Next Meeting

17 January 2023 at 9.00am