North West London Acute Provide Collaborative Strategy 2024-2027

Contents

Foreword

1. Introduction
2. Our mission
3. Our vision
4. Our diagnosis
5. Our response
6. Our action plan
    a. Clinical outcomes
    b. Performance and productivity
    c. Research and innovation
    d. Data and digital
    e. People
    f. Estates and sustainability
    g. Other non-clinical and support services
    h. Anchor institution responsibilities
7. Conditions for success
8. Measuring progress
9. Conclusion

Foreword

The 2.2 million people living in north west London rightly expect healthcare to be delivered based around their needs and not NHS structures. Our strategy takes a significant step forward in putting their expectations first. Building on what our teams have achieved to date, it outlines our focus to deliver high quality, equitable and sustainable health care. This is an aspiration which can only be achieved by working together and combining our knowledge, skills, and experience.

Our strategy describes our approach to engage our staff and maximise our collective expertise, resource, and partnerships to set and raise standards of care for our patients, offer the best care available to everyone, and be one of the best places to work in the NHS.

This strategy sits above and supports our individual trust strategies. We believe by aligning our best practices to the best in north west London, the best in the NHS and the best in the world we can more quickly and effectively achieve our individual goals to the benefit of our local communities, within the financial constraints that we face.

Our shared approach to improvement supports our roles in the North West London Integrated Care System. We will focus on improvements that are shared priorities agreed with our partners and the service leadership within our organisations. This strategy will strengthen how we make changes together across our acute services so that we can work with our partners to address complex, system-wide issues more effectively in the years ahead.

This strategy sets out our mandate for change. We aspire to do things as well as we can across our collaborative. We will look for what best practice is and work to deliver this in each organisation. As such, we are asking every service, large or small, to re-imagine its future around the needs of patients, populations, and place, and not the limitations of serving separate NHS organisations. We will use our collective research, innovation, and continuous improvement to continually raise these standards. All our data will be shared transparently across our collaborative to inspire ideas and measure improvements to make sure changes are implemented effectively.

This strategy is an invitation to join our movement for improvement. We now want our staff to be open, curious and transparent as they collaborate with colleagues across north west London and provider excellent clinical outcomes, equity, access, and experience for our patients and communities.

Matthew Swindells, Tim Orchard, Lesley Watts, Pippa Nightingale and Patricia Wright

1. Introduction

1.1 What is the North West London Acute Provider Collaborative

1.1.1 Our North West London Acute Provider Collaborative (APC) came into being in September 2022 and includes the four acute trusts in north west London:

- 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

1.1.2 Between us, we run 12 hospitals across eight boroughs. We employ 33,000 staff and serve a local population of around 2.2 million with a combined expenditure of approximately £4bn annually. We also provide regional, national, and international specialist services.

1.1.3 The APC is a collaborative of four statutory organisations, each with a trust board that is responsible for setting strategy and delivering statutory and regulatory requirements for each trust. While each trust board remains responsible for the delivery of their respective trust duties, we have agreed key principles regarding how we work together, including taking collective responsibility for the success of the collaborative. As a collaborative, the four boards work together through the Board in Common to hold each other to account and deliver common strategic priorities that have collective value. We are all part of the North West London Integrated Care System and committed to supporting improvements in the health and wellbeing for our population and reducing inequalities in outcomes, access, and experience.

1.1.4 This approach means the trusts remain independent organisations, with their own strategies and work closely with their local authorities, patient groups, and other partners. But being a collaborative means we can raise the quality and efficiency of our services and make more effective use of our collective resources to provide better care, for more people, more fairly.

1.1.5 We have an Executive Management Board for our APC, to allow executive decision making within the collaborative. Our Board in Common assures and oversees progress and performance through thematic collaborative committees such as Quality, People, Finance and Performance, Digital, and Estates and Net Zero.

1.2 Who do we support

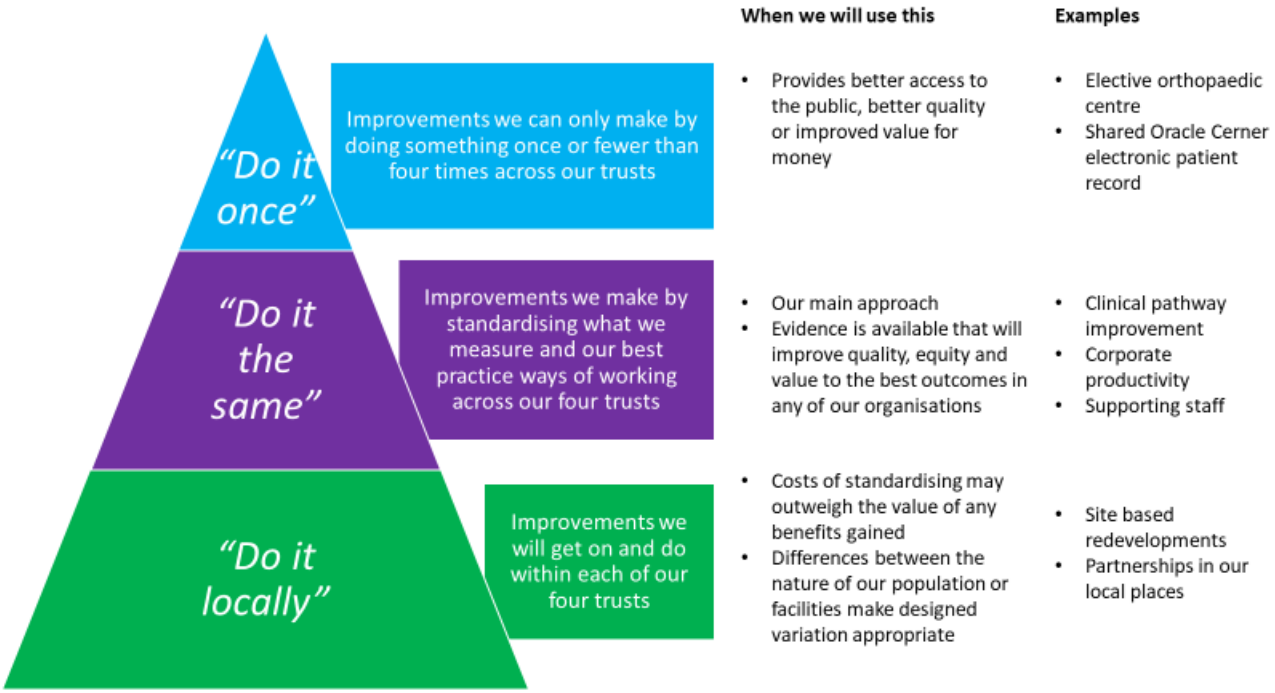
1.2.1 Most of our patients come from across north west London, though our specialist services support regional, national, and international patients. Our local population is amongst the most diverse in England with people from nearly 200 ethnicities. While our population is younger than average, where median ages are between 35 and 40 in each borough compared to an English median of 40, there are many people aged over 65 where demand for acute healthcare is highest. Our population is expected to grow by 800,000 people over the next 20 years. This growth is concentrated in those aged 20-29 and amongst over 60s which will increase healthcare demand.

1.2.2 Although north west London is slightly wealthier than national averages, one in eight of our residents live in the 20% of the poorest neighbourhoods in England. Health inequalities in life expectancy are stark and increasing with a 20-year gap between the most and least deprived members of our local communities. Health inequalities are also very local where there can be a 15-year gap in life expectancy between neighbourhoods within a 15-minute walk of each other. People in our poorer neighbourhoods develop multi-morbidity 10-15 years earlier than people in wealthier neighbourhoods. Long term conditions with the greatest local prevalence are asthma, depression, diabetes, hypertension, and chronic heart disease. Lifestyle factors including obesity have negative impacts, and compared to England averages:

- four of our boroughs have a higher smoking prevalence.
- seven boroughs having higher hospital admissions due to alcohol.
- seven boroughs have lower number of adults meeting the '5-a-day' recommended fruit and vegetable intake.
- four boroughs have higher proportion of physically inactive adults.

2. Our mission

2.1 How we work together



2.1.1 Our APC approach to how we should intervene is to view improvement through three lenses:

- **"Do it once":** What should we do once or fewer than four times, on behalf of everybody? We don't see centralisation as a "good" in its own right, but something that we should do if it provides better access to the public, better quality, or improved value for money. We expect a small number of important functions to move in this direction in the coming years.
- **"Do it the same":** What should we do four times, but adopt a common definition of best practice and measurement everywhere? This is an area which takes advantage of the wide variety best practice guidance that is available alongside our local benchmarking to drive improvement. We expect a significant movement towards this approach in the coming years.
- **"Do it locally":** What simply should be defined and managed locally? These are areas where standardisation would simply add bureaucracy and cost or where difference in the nature of our local communities or our facilities makes designed variation appropriate.

2.1.2 Our governance supports this approach to working together. Each of our CEO leads a thematic workstream such as Quality or People and Inclusion. These workstreams progress priorities that have been agreed across our collaborative, including initiatives such as the Elective Orthopaedic Centre, where we are providing one service together. Initiatives are supported by teams drawn together across our four organisations, with implementation of standardised ways of working managed within each organisation. Progress and performance are assured by our Board in Common and its committee structure.

2.2 What we achieved together so far

2.2.1 Our four trusts have been collaborating since before the pandemic with initiatives such as the NIHR Clinical Research Network and West London Children's Healthcare. This rapidly accelerated in response to COVID-19 with sharing of ITU resources, collaboration for vaccine development and delivery and working together across clinical and operational teams to support our patients access safe, timely care.

2.2.2 Since our APC was established, our collaborative approach has helped us to:

- Offer patients waiting for an operation to have their operation sooner by moving to a hospital managed by another trust if there is more capacity for that service.
- Expand a single electronic patient record system to cover all 12 hospitals of the four acute trusts, bringing immediate benefits for patients whose records and information can be shared with healthcare providers across sites so they can receive seamless care and creating huge potential for improvements in population health through data-led research.
- Improve inpatient orthopaedic care across the sector with the opening of the North West London Elective Orthopaedic Centre. This has allowed us to bring together routine, low complexity orthopaedic procedures in a single centre of excellence which will improve outcomes, allow us to treat more patients more efficiently, and reduce the risk of operations being cancelled due to urgent and emergency care pressure.

2.2.3 Our individual trust strategies share many similar priorities, including a focus on quality of care, equity, sustainability, and people. Engagement with staff when developing this strategy has highlighted the value they place on collaborating with colleagues doing similar roles in partner trusts and desire for opportunities for joint efforts and shared learning to increase. These principles and behaviours of partnership give us a strong foundation for more collaborative working.

2.3 Our statement of intent and long-term ambitions

2.3.1 In October 2022 our board-in-common agreed a statement of intention and vision for collaboration. As we looked ahead over the next ten years, we set out with the ambition to:

- Create the best acute provider system in the NHS, which is admired around the world.
- Create the best place to work in the NHS with the opportunity for staff to develop their careers and fulfil their aspirations within north west London.
- Constantly challenge the status-quo to drive more effective and efficient healthcare and maximise what can be achieved with the available funding.
- Work with local academic institutions and businesses to create a global centre for health research and innovation with supports better healthcare and creates jobs in north west London.
- Work with our partners to the NHS, local government, the voluntary and the commercial sector to help create a healthier, more prosperous, fairer north west London.

2.4 Why we need a strategy and its scope

2.4.1 We need an APC strategy to guide and prioritise how we more effectively work together as four organisations. This will support the implementation of each of our individual strategies and the shared priorities and joint forward plan agreed with our partners in the North West London Integrated Care System. This strategy describes how we have agreed an approach to making improvements that harness our collective resources and expertise for the equitable benefit of our patients, communities, and staff – and describes what collaboration can deliver beyond what individual trusts can do alone. This approach includes shared principles and priorities that will help each of us learn quicker, improve faster, provide higher quality care and be more productive than we ever could alone.

2.4.2 Across our trusts, we are proud to offer truly excellent services in many areas. But we also recognise that there is variation in care quality, how our patients access our services, the experiences they have, what their outcomes are across north west London, and the opportunities for our staff. This is reflected in significant variations in health outcomes, life expectancy and healthy life expectancy within our population, and staff feedback. We believe that everyone should be entitled to the same high standards of care, employment, and opportunities that we offer when we are working at our best in our collaborative.

2.4.3 For this strategy, we sought to answer: *"How can the APC most effectively use our collective resources to provide better, more equitable care for the population of north west London, over the next three years?"*

2.4.4 The APC strategy sits above the organisational strategies and sets out what we will work on as a collaborative, focusing on the things we can only do most effectively together.

2.4.5 This document uses our approach to how we should intervene and sets out the actions we need to prioritise over the next three years to meet our shared ambitions of higher quality care within, and greater equity across, our organisations. Our shared priorities focus on enablers such as data, skills, and networks of expertise that empower our staff to lead local and collaborative improvements towards our shard goals and improvements within each organisation.

2.4.6 Each trust remains an individual organisation with its own organisational strategy. We will continue to have individual trust priorities and approaches. This strategy has been developed recognising fixed points, including that we will each remain independent and that there are some things we will all continue to do, for example providing emergency and maternity services to our local populations.

2.4.7 We will also be working closely with other north west London partners (for example the integrated care board) to deliver wider healthcare priorities across our area. This includes support towards our local ICS strategy and across the nine priorities agreed in the Joint Forward Plan published in April 2024. Our contribution to this plan will be strongest in reducing inequalities and improving health outcomes, providing the right care in the right place, transforming maternity care, increase cancer detection rates and delivering faster access to treatment, and transforming the way planned care works. Our strategy has been developed considering how we can use our collective resources and a shared approach to improvement to meet these expectations.

2.5 Approach we took to creating our strategy including our wide-ranging engagement

2.5.1 We have engaged over 1,300 staff on our APC Strategy across all four trusts, including:

- Leadership workshops to identify opportunities and challenges.
- APC-wide online staff survey.
- Engagement during each individual trust's leadership briefings and all staff meetings.

- APC-wide online workshops.
- Board development workshops.

2.5.2 We also pursued targeted engagement opportunities with patients and members of the public through existing forums and reached out to trusted partners across health, social, voluntary, academic, and other sectors to test our approach. We used numerous local data sources collected during recent engagements with staff, patients, and our local communities, as well as regional and national sources to understand current public opinion and perspectives.

2.5.3 We developed our strategy in a similar way to how we treat our patients. First, we developed a "diagnostic" of our current context, opportunities, and challenges. This is like when we seek to understand what root causes are creating a patient's needs and the outcomes they want to achieve. Informed by our diagnostic, we prioritised a "response" that we believe would best achieve our vision given everything we face and have available to build upon. This "response" then informed our "action plan" to make sure we are implementing changes effectively and measure progress along the way, in the same way we set out treatment plans for our patients to get the care they need.

3. Our vision

3.1 Our vision for the next three years is that:

We will use our collective expertise, resource, and partnerships to set and raise standards of care for our patients, offer the best care available to everyone, and to be one of the best places to work in the NHS.

3.2 This vision has been developed through engagement with our staff and will communicate our immediate aspirations towards our longer-term statement of intent agreed in October 2022.

4. Our diagnosis

4.0.1 Through our diagnostic, we have sought to identify the most critical challenges to achieving this vision and the strengths we can use to help us.

4.1 Strengths

We can build on our strengths to achieve our vision and address shared challenges. Our strengths include:

4.1.1 **Quality:** Across our organisations, we have some of the best standardised hospital mortality ratios in the NHS demonstrating safe and effective care. We have countless examples of leading services, clinical outcomes and practice, innovation, and positive patient experiences to learn from and share.

4.1.2 **People:** The APC has a significant diversity of our staff which offers deep connections with our communities and world-leading breadth of skills, expertise, and lived experience. Our people are a priority across our trusts and our collective Staff Survey results show we have strengths in staff development and teamwork.

4.1.3 **Digital:** We have the same electronic patient record in use across all our organisations, which gives us a platform for measuring, understanding, and addressing unwarranted clinical variation.

4.1.4 **Research and innovation:** Strong research infrastructure, partnerships and assets means we are well placed to combine research and innovation opportunities, including the use of large datasets that can support life sciences innovation such as AI, immunotherapies, genomic medicine, and gene editing.

4.1.5 **Individual strengths:** Each trust has local approaches, cultures, and expertise which they can share learning and leadership to the benefit of all.

4.2 Challenges

4.2.1 The key challenges we together face are:

4.2.2 **Variations in our clinical outcomes and patient experience**: While we have some of the best clinical outcomes in the NHS, our patients experience different clinical outcomes between our organisations and have different experiences depending on where and by who they are treated. All the trusts have different strengths but there are significant variations across common services between our organisations and at times within organisations. This includes access to clinical research and trials of leading medicine, which varies markedly according to the hospital in which you are treated and should be viewed as a health inequality. Often our services have not been effectively and equitably co-designed around patient and population health needs. Sometimes patient outcomes and their experience of care is poor.

4.2.3 **Performance and access:** When viewed in a national context, our operational performance is good. However, our patients experience significant differences in access to timely services within and across all our organisations. Our performance reflects a nationwide context made more challenging by Covid, and we all have patients waiting more than 52 weeks for elective care, more than six weeks for diagnostics, and more than 12 hours for emergency admission or treatment. Patients have frequently shared their perspective that they value the quality of our care once they have accessed our services but are anxious about how long they may have to wait to do so and how poorly information while waiting can be communicated.

4.2.4 **Finance and productivity:** When benchmarked nationally and within London our hospitals are amongst the most efficient, all with reference cost lower than the national average. However, there is no question that the NHS is seen a reduction in productivity since pre-COVID and whilst ours is one of the smallest drops in the NHS, it is there nonetheless, and efficiency varies between services across all our organisations. Financial pressures on our organisations are great and our staff are working hard, so we must find way to improve efficiency by changing the way we work, making sure care is always provided in the most appropriate setting, investing in new equipment, and investing in information technology to deliver more care and a better working environment within the resources available.

4.2.5 **Staff engagement and inclusion:** Our staff surveys show staff engagement and wellbeing is increasing across our APC but is still little better than 2020. This is an ongoing challenge for us all. There are variations in how empowered and engaged our staff feel in improving services. We need to do more to make sure our staff feel included and belong,

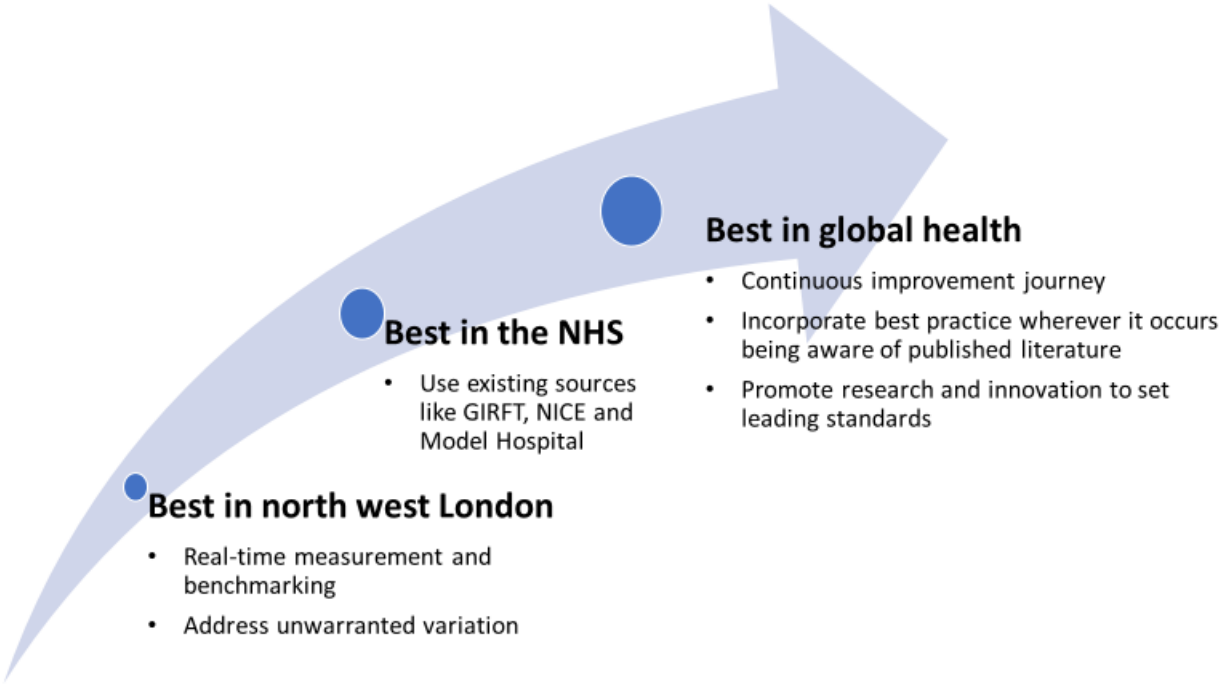
especially our global majority staff and staff recruited internationally as their feedback is worse than average. In addition, our workforce will continue to experience significant change and challenge, driven by growing patient needs such as multimorbidity, new technologies, and wider pressures including local housing costs and quality, and cost of living.

4.2.6 **Estates:** Some of our estates are in poor condition. Of the top ten trusts with highest backlog maintenance in the country, three of these are in north west London. This leads to staff having to take workarounds, impacts our productivity, and means we have a poorer environment and experience for patients and staff. Two trusts have significant redevelopment projects for their estates.

4.2.7 **Changing local context:** We recognise that there is lots changing around our organisations, including population need and declining public perceptions of the NHS. We need to work better with our partners on these issues which impact us all. Our challenges include:

- We need to respond to the shared priorities in north west London including population health management, timely discharge, maternity, cancer care and planned care. However, this takes place against a background of relative immaturity in system working, where there are unclear lines of accountability between partners and unestablished abilities to hold each other to account. This includes relationships within our APC where we are now building greater trust and collaborative ways of working after many years of public policies encouraging competition and difference between our organisations.
- There are changing population health needs and population health management approaches. There is now much greater recognition that targeting unwarranted variations in patients with multi-morbidities, from minority ethnicities and higher areas of deprivation will see the greatest gains in equity and support overall improvements in outcomes.
- Public/patient trust in the NHS has eroded since its highest point in 2010 and this fall has accelerated since Covid. Declining public support has consequences including increasing incidents of aggression and violence towards our staff.

5. Our response



5.0.1 The patients we care for across north west London and beyond should have access to the same high and rising standards and achieve excellent outcomes wherever they access our services.

5.0.2 Our vision is to use our collective resources to set and raise our standards of care and offer the best care available to everyone. To do this, our approach to change will be to work with each other, patients, partners, and communities to understand and agree what the best outcomes are, what best practice looks like in north west London, the NHS and in global health to achieve these outcomes, and then use our data to evidence and support improvements to consistently achieve and then raise these standards. Aligning to best practice is our means to deliver the results of better patient care, more productive and better value services and being the best place to work. It means that all our staff will engage with colleagues across our APC, patients, communities, and partners to understand where there is variation, what the ideal model would look like and raise standards across our APC to meet that best practice.

5.1 Our priority improvement objectives

As we encourage and enable change across our organisations, we will expect every leader and clinician to consider three priority objectives in their thinking and improvement. They need to consider how their efforts and changes will:

1. Improve equity, outcomes, and access for our patients, working with patients, communities and partners to understand problems from their perspective and implement best practice and best value solutions.
2. Adopt the most productive, sustainable, and efficient ways of working.
3. Be one of the best places to work in the NHS.

5.1.2 These improvement objectives collectively reinforce and support each other. Improving quality and value leads to better performance, which leads to greater productivity, which leads to a more fulfilling and effective working environment. Providing high-quality, equitable care and access is the right thing to do. It also supports productivity, as getting things right first time, every time, supports reductions in waste and cost. Higher quality care and lower costs increase value. Focusing on value means we prioritise our limited resources towards what makes the biggest difference to patients' health and outcomes. We know a commitment to high quality care and value will engage our staff and is only possible by making the most of their talents and potential, and therefore supports being a great place to work.

5.1.3 When setting our ways of working and standards to the ones in our APC that achieve the best outcomes and the best value, we believe these same practices will most frequently also be more productive and lower cost. These efficiencies from scaling better value care and ways of working will be needed to address our underlying financial deficit and be reinvested in clinical improvements and functions like digital and organisational development where additional resources are needed to enable our response.

5.2 Our approach to improvement

5.2.1 We will work closely with our patients, communities, and partners to incorporate what best practice means for them into our approach, and at the same time improve how we work with our patients and communities as a collaborative. Working together, we will use the existing evidence as to what best practice is today, combined with the deep experience of our patients, insights from our partners and our research and innovation to set new higher standards.

5.2.2 Evidence for what is best practice may be within our trusts already, or we may find it nationally or globally. The great advantage of our collaboration and common digital tools over working alone is that we can always compare our outcomes and value across north west London to learn from each other, identify the best local practice, and identify where poor outcomes need to be prioritised for improvement. Our ambition though is not limited to what is best practice or best value within our trusts. Where it exists, we will seek the insights and comparisons nationally such as Getting It Right First Time (GIRFT) to match the best in the NHS. We will also look for learning from globally leading organisations, along with research we are undertaking, to raise our standards and continuously improve to provide the best in global health. Working in this collaborative approach will support excellent and improving outcomes for our patients, not just levelling out the care we provide to achieve average local outcomes.

5.2.3 Having engaged widely and agreed best practice standards, we will use our data and digital tools to better measure and benchmark outcomes including clinical care, access to services, patient experience, value, and productivity. We will share and constantly update these insights in timely ways to support teams continuously improve towards and beyond best practice standards. Our teams will be able to proactively use our shared data, improved training on improvement skills, networks of expertise formed across our APC and shared values of curiosity, openness, and excellence to make positive changes. By aligning to best practice, and constantly learning and improving together, we can raise standards and value across our APC and constantly drive better practice. We believe working together to empower our staff and creating a collaborative movement for improvement is the most effective way to equitably improve outcomes, access, experience, and value for our patients.

5.2.4 As a final nuance to our approach, there may be times that the value created from aligning to best practice costs more than the effort to standardise these changes across our organisations. Our focus on value means we expect there are a few improvements that are best done once and together, many that will be supported by standardising how we work, and some that are best left to each organisation to improve independently.

5.3 Why this approach

We have prioritised this response over the other alternatives we considered because it:

- Helps us meet our statement of intent and vision by offering a guiding set of principles for working together including involving patients and staff in designing improvements, transparency about performance, openness to learning and sharing,

and encouraging consistency. This approach is as relevant to all our areas of activity including supporting our people, other corporate services and how we play our part in our local communities.

- Creates a strong foundation, including with joined-up information, new staff networks, and organisational development to provide a future platform for potential bolder, innovative improvements and changes across our organisations and working with partners to transform the health and care system in north west London.
- Focuses on action and continuous improvement for immediate benefits over planning more complicated and potentially disengaging service configurations.
- Address our challenging context, including improving poor and variable care outcomes and experiences by adopting consistent, evidence-based best practice, and working within available financial resources where we will generate efficiencies.
- Focuses on where we can add value as a collaborative over and above what individual trusts can achieve.

5.4 What this means for our people

5.4.1 We will adopt a collaborative approach to how our staff work. We expect them to determine best practice first across the collaborative, then the NHS and beyond for their area of expertise. It is about how we work together as much as we work on. This change model is the same whether it is a dedicated team supporting an initiative prioritised across our collaborative, or people looking at ways of continuously improving how they work and provide care. It is as applicable to linen services as to pharmacy as to the redesign of a clinical pathway. It means our staff need to change how they think and act when making changes to use their curiosity about how their service or teams' outcomes compare to others in our APC and beyond and what they can learn or share with others.

5.4.2 This approach cannot be successful if it is simply a series of top-down initiatives. We know we cannot prioritise dedicated resources and improvement efforts against everything at the same time. The implementation of this strategy will be a combination of the prioritisation of centrally sponsored change programmes and local initiatives.

5.4.3 The Board will begin with issues, pathways, and functions where our APC agrees with teams that the evidence shows our patient outcomes are poor, where we have significant variation between our organisations, where we offer poor value, or where there are significant sustainability challenges. These priorities will inform where there is senior

leadership facilitating and focusing support to improve things using our collaborative approach.

5.4.4 At the same time, we believe this change approach will drive progress over many areas by engaging and using the ideas, experience, and skills from our 33,000 staff. In all their work and improvement efforts, the same principles and approaches should be applied. We will help them use data, benchmarks, best practice evidence, networks, learning and sharing across our collaborative, and co-design with patients and communities to support improvements against any issue. The challenge of comparing your outcomes transparently with others is intended to promote a culture valuing high performance and excellence. Senior leaders will need to support teams in this with the data and improvement skills training they need, as well as clear governance arrangements and lines of accountability to ensure decision making not slowed down by the complexity of working across four organisations.

5.4.5 This means our approach to change can guide us across everything we do for the next three years, from improving patient outcomes to providing better career opportunities and to meeting our social responsibilities as anchor organisations in our communities. This is not a safe or easy approach, but requires significant changes in our cultures, use of data, and empowerment of our staff to lead improvements and innovation through a bottom-up movement. It also requires greater engagement and co-production with patients, communities, and partners to deliver best practice and better value. Our commitment to align to best practices puts our population and patients before our individual institutional interests or historic ways of working.

5.4.6 In our action plan that follows, we identify initiatives for which executives will be accountable and that will be prioritised for dedicated collaborative support. Our model of change and these three objectives applies to any change we do. This is because we want our teams to be ambitious, impatient, and support this same change model and process. When they see an issue and are making continuous improvements in what we do, they will need to prioritise these three objectives. Wherever someone is working and providing care, you will be working together and learning from across our four trusts.

5.4.7 This means we expect in three years' time:

- Patients will access high-quality care sooner, find their experience more personalised and centred around their needs, and benefit from excellent, equitable clinical outcomes whichever hospital they attend in north west London.
- Partners will benefit from consistent ways of working and communicating information and be working closely with APC colleagues progressing shared priorities across north west London.

- Staff will move more easily across trusts, be able to apply their curiosity to explore timely information on how their team performs and compares to others, have stronger networks and working relationships across organisations, deliver better care and will see noticeable improvements in north west London as a place to work.

5.4.8 In developing this strategy we have reflected what working together adds above each trust. As an example, working alone all our strategies seek to improve the quality of our care. Without our collaboration, we would have our teams implementing their own ideas and, where they can, translating external best practice examples. By working together and guided by our response, we can quickly provide comparable insights to benchmark every element of our performance, share expertise, and identify ways to improve that can quickly be scaled. This will support our teams more quickly raise standards of care and support each of our organisations implement priorities within our strategies.

6. Our action plan

6.0.1 Our response applies to all our areas of work together as a collaborative. In the following section, we have outlined what this will look like in practice over the next three years and the actions we will take across critical areas. For each, we explain how the area links to our overall response; what will be different for patients, partners, and staff in 3-years' time; our main actions in this area; how we will measure progress; who will be responsible; and immediate next steps.

6.0.2 We publish this strategy while already progressing some immediate initiatives we have agreed as a collaborative and manage through our governance structure and Committees. These are supported by this strategy and our approach to sharing and standardising best practice.

6.1. Clinical outcomes

6.1.1 **How does this link to our overall response?**
To improve and to reduce variation in outcomes, equity, experience, and access for patients, we will work to make sure we set the same high standards of care across our collaborative, constantly improving and aligning our approach to what evidence shows is best practice for delivering excellent patient outcomes. We will involve patients, communities in partners in prioritising the clinical outcomes and experiences that matter most to them and to apply and set the best practice ways of working needed to achieve these equitably.

6.1.2 We will choose where to focus our efforts to raise standards depending on where we see poor outcomes, significant variation in patient outcomes, equity, and experience, and where we know there are issues to access services due to long waits. We will use clinical pathways as our primary approach to organising our collaborative improvement efforts and prioritised initiatives. We will support our staff engage with our patients, communities, and our partners, because we know that care does not begin and end in our hospitals which means improvements need to support better health and ways of working across our system. This will also help us address the challenges of supporting improvements across our system and population health.

6.1.3 Patient needs are though complex and are not organised neatly into pathways. Although our primary approach will be pathways, we will support clinical networks and identify where we can work together to improve outcomes across population groups such

as children and young people, patient segments such as people with multiple long-term conditions or serious mental illness, and cross-cutting outcomes such as care at the end of life.

6.1.4 We believe that as well as delivering better, more equitable care, aligning to best practice will be more productive and cost efficient. This means that improvements should be achieved within our existing resources. In practice, we expect reductions in the average cost of care from some of our pathways and services to enable us to agree prioritised investments that improve clinical outcomes and equity in other pathways and services.

6.1.6 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients will access excellent care, experience, and outcomes whichever hospital they attend in north west London. They will have greater choice in accessing care across sites, for example when needing diagnostics, and digitally because of greater consistency in how we work. Their experience will be better because many pathways have been redesigned incorporating co-design and co-production principles.
- Partners will benefit from consistent ways of working and communicating information about our patients. Best practices in providing care and expertise outside of acute hospitals will have been incorporated into redesigned pathways.
- Staff will follow best practice pathways with clinical tools, systems, and ways of working designed to make the easiest thing to do the best thing to do. They will have closer working relationships with their peers across our APC, comparing their clinical outcomes transparently, openly, and curiously to learn and share good practice.

6.1.7 **What are the critical actions?**

- Each specialty will choose at least one priority pathway each year to improve, raising standards and aligning our approach across the collaborative to best practice to improve patient outcomes. Pathways will be prioritised by key factors such as poor outcomes across all trusts, variation between trusts, inequity between population groups, workforce challenges, patient volumes, and costs. These priority pathway improvements will be sponsored by executive leaders who will use these initiatives to test, strengthen and accelerate common enablers like access to data, integration into digital tools, and skills training that can then be used to support a broader movement of improvement.

- Clinical networks across our APC will discover and understand what each organisation is doing, the outcomes they achieve, and agree the few outcomes measures they will prioritise.
- The clinical networks will engage widely with patients, communities, and staff, as well as looking at local, national, and international evidence, to understand best practice for this pathway and work to implement this across north west London. Clinical outcomes, performance and productivity data will be shared visibly and transparently, so we can benchmark across other organisations, national or international practice.
- Complementing the focus on pathways, we will implement improvements and best practice standards across quality themes where efforts are already making progress, including infection prevention and control, mental health in an acute setting, care of the deteriorating patients, end of life care and user insights and focus.

6.1.8 **How will we measure progress?**

- Across our APC we will track the prioritised pathways and the outcomes agreed by the clinical teams and expect to see improving quality standards and reduced variation between sites, teams, and individuals.
- Our quality governance will continue to closely track and measure our outcomes in pathways that are not prioritised for improvement each year. We would expect their current performance to be at least stable, if not gradually improving, as local teams and innovations support continuous improvement.
- We will also track progress by measuring our overall strategy metrics.

6.1.9 **Who will be responsible for this?**

- Each specialty/pathway will also have a clinical lead and a Specialty Leadership Group, comprising of a clinical representative from each trust. This group will be responsible for pathway redesign.
- Each CEO in the collaborative will oversee the progress of several specialties. Improvement support will be organised from within the lead CEO's trust, such as project management or analytical capacity. The CEOs will have responsibility for reporting progress and escalating any issues to our APC Executive Management Board.
- For outcomes that cut across clinical pathways, the Collaborative Quality workstream and its lead CEO, reporting into our APC Quality Committee, will be responsible for overseeing improvements. This includes areas such as specific

patient populations like children and young people, segments like patients with multiple long-term conditions, or cross-cutting themes like mental health in an acute setting.

6.1.9 **What are the immediate next steps?**

- Appointing clinical leads and the specialty leadership group to begin the specialty redesign.
- Agreeing priority pathways for the first year of the strategy, agreeing the priority outcomes, the best practices to achieve these and how to implement these consistently across our APC.
- Progress and finalise implementation of improvements and best practice across collaborative quality priorities.

6.2 Performance and productivity

6.2.1 **How does this link to our overall response?**

Access, performance and how we value patients time have important impacts on patients experience and are a priority amongst our local communities. They also impact clinical outcomes, reducing the risks of deterioration and complications. Increasing our productivity is the fastest way to expand our capacity to support patients who need care.

6.2.2 We will work to set and raise standards of performance and reduce variation between our organisations by agreeing and implementing the most productive ways of working. Reducing waste and getting the most value from our resources will support improvements in patient care, performance and create opportunities to reinvest and redeploy savings into innovations that improve quality. It will also improve staff experiences by addressing frustrations that waste time and unsustainable workloads.

6.2.3 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients will have shorter waits for care than today. Significant progress will have been made to restore NHS constitutional standards in planned care pathways, fewer people will have long waits for emergency care, and fewer patients will be delayed reaching the most appropriate care setting once they are medically fit. Patients will experience a much greater focus on their convenience and value of their time, with services implementing shared best practices such as "one-stop shop" models and making it easier to share and access information and care remotely.

- Partners will find it easier to get specialist advice to help people they also support. Where we interact such as at discharges, improvements in productive and efficient processes will reduce the delays and confusion that can happen today.
- Staff will find work easier and more rewarding because of reductions in the frustrating obstacles, waits, and waste that get in their way of providing excellent care.

6.2.4 **What are the critical actions?**

- Improvements to performance and productivity will be integrated with efforts to align best practices within clinical pathways and support services, because excellent quality outcomes, equity, and experience are directly linked to access.
    - In prioritising the pathways we will address first, we will consider where there are variations in or poorer performance in access to services, because this impacts on our potential to achieve excellent, equitable clinical outcomes.
    - Best practices adopted will incorporate measures and evidence to improve performance, productivity, efficiency, and value alongside quality.
    - Improvements in non-clinical support services will prioritise improvements in productivity while maintaining and improving current performance, so that resources can be reinvested in improving clinical outcomes and digital enablers.
- We will set and raise standards on common clinical enablers that significantly impact performance and productivity by standardising our ways of working and systems to achieve best practices, including patient scheduling, waiting list management, outpatient clinic administration, operating theatre utilisation, average inpatient length of stay, and discharge processes. Improvements in the productivity and value of these common enablers will support overall reductions in cost to address our underlying deficit and allow prioritised reinvestments to improve clinical outcomes.
- Information about performance and productivity measures will be shared transparently across our organisations and incorporated into shared dashboards to support learning and improvement. These measures will include outcomes including session/clinic utilisation, turnaround times, average length of stay, workforce models, premium pay rates, non-pay expenditures, and estate/asset utilisation.

6.2.5 **How will we measure progress?**

We will track productivity and performance measures within each specialty, across each trust to support shared accountability and across our APC to support prioritisation in where we need to share best practices and act differently.

6.2.6 Priority measures to demonstrate improvement are:

- Elimination of patients waiting over 52 weeks from referral to treatment.
- Improvement against the 18-week wait referral to treatment time NHS constitutional standard.
- Reduction in patients waiting more than 12-hours and 4-hours when attending Accident and Emergency Departments.
- Reduction in the number of patients medically fit for discharge but occupying an acute bed.
- Reductions in the average cost per weighted activity unit.

6.2.7 **Who will be responsible for this?**
Improvements will be primarily led through the clinical pathway and non-clinical support services initiatives. Action across common enablers supporting performance and productivity will be overseen by the Chief Operating Officers. Improvements supporting improved measurement of productivity and resource utilisation will be led by the Chief Financial Officers. Collectively, they will report progress through to the Finance and Performance workstream and its lead CEO, with our APC Finance and Performance Sub Committee assuring direction.

6.2.8 **What are the immediate next steps?**
Support the clinical pathways and non-clinical support services improvement initiatives to identify best practices and standardise across our organisations.

6.3 Research and innovation

6.3.1 **How does it link to the guiding policy?**

North west London is home to excellent research and innovation assets, including a world class academic institution and global industry. There are also strong, longstanding working relationships and collaborations between partners, most notably through the NIHR North West London Clinical Research Network. The result has been significant numbers of patients benefitting from access to the latest treatments and technologies, and at the same time staff have benefited from the experience of being involved in their development

and delivery. We know that participation in research trials improves outcomes for our patients, as well as providing skills development for our staff.

6.3.2 Research's biggest challenge across the country is that there is significant variation in access to research participation and innovation for different population groups, and this is the same issue in north west London. To provide better access to patients, more opportunities for staff and to further attract academic and industry partners and investment, we need to unrelentingly focus on improving equitable access to research trials and innovation in north west London.

6.3.3 Increasing commercial research partnerships will create a virtuous cycle of increasing our income and resources, which can be invested into broader support for research and innovation. New sources of income will help us address our underlying financial deficit and they also bring wider economic benefits for the UK economy.

6.3.4 Broadening staff access to research will support recruitment and retention of talented, innovative colleagues and make our APC one of the best places to work in the NHS.

6.3.5 **What will be different for patients, partners, and staff in three years' time?**

- The population we serve will have improved equity of access to research trials that they are eligible for, and overall numbers of research participants will increase. This will mean that patients across the collaborative will have more equitable access to the newest treatments, technologies, and procedures, benefitting in turn from improved outcomes.
- Academic and industry partners will find it easier to work in north west London than other parts of the NHS, with simpler, efficient processes to establishing feasibility and then research, and with access to a larger, more diverse population.
- Staff will be able to conduct research with more support, across wider networks of partners and with improved research skills.

6.3.6 **What are the critical actions?**

- Promote a research and innovation culture.
    - Continue to invest in growing and widening access to our research networks that support the development of connections, peer learning, and staff training in research skills.
    - Place greater emphasis on research and innovation within job roles and descriptions to build a skilled, multi-disciplinary workforce.
    - Actively promote a culture of learning and curiosity to support research and innovation, through consistent leadership across our APC.

- Grow the breadth, depth, and impact of our trusted research environment.
    - To grow the breadth, depth, and impact of our existing NIHR BRC hosted trusted research environment, we need to strengthen collaboration and partnership between the research teams working across trusts and universities in north west London. This also means adapting the governance around data to ensure all key stakeholders can influence decision making to support trust and engagement.
    - As a collaborative we will adopt best practice ways of working to speed up effective trial set-up times to our partners.
    - We will use the systems and tools already available to us to support the identification of patients who meet study/trial inclusion criteria across our APC rather than by individual trust.
- Reduce the inequality of access to research and trials across the collaborative.
    - Access to research and trials should be determined by your clinical appropriateness, not the site on which they have their diagnosis or treatment.
    - Not every hospital will be awash with Chief Investigators, but every CI should be thinking about how their study or trial can be easily accessed by clinicians and patients across the collaborative.
    - As a collaborative we will identify and adopt the best model to support the spread of research across the collaborative.
- Improve management and coordination to help colleagues lead innovation, as the administration in research is a significant burden. By improving the coordination of R&D, ethics, and administrative functions will support staff to focus time and resource towards conducting research and adopting innovation.

6.3.7 **Potential measures of progress**

- Develop a new measurement to track rolling monthly recruitment to all studies and clinical trials, to drive an increase in the total number of trials, the percentage of trials available in the UK that could be available to our patients that are available, and the number of patients recruited across the trials.
- Develop new measures to contextualise recruitment to trials with population level eligibility data to understand and improve the equity of access.
- 90% of commercial studies open at the first site within 60 days of the HRA approval.
- Proportion of open studies on track, delivering to time, and target.
- Establishment to first participant recruited.
- Patient and staff experience of research.

6.3.8 **Who will be responsible for this?**

- Within our APC, this work will be led by our Research and Innovation functions reporting into their responsible Executive Director and then our APC Executive

Management Board. Overall progress will be overseen by the Quality workstream and our APC Quality and Safety Committee.

- Improvements within our APC will be complemented by working with the North West London Research and Innovation Board.
- The research and innovation landscape is complex and undergoing transition. It is vital to gain a shared understanding of structures, roles, and responsibilities across north west London, further broadening opportunities and links with our other health and care partners.

6.3.9 **What are the immediate next steps?**

- Establishing a shared understanding of structures, roles and responsibilities for research and innovation across north west London.
- Build on the existing working with the NIHR Clinical Research Network to develop opportunities for APC Research leaders and other staff to build connections and collaborations.
- Identify and align to best practice on centralising and streamlining approval and support processes, including data sharing.
- Review job roles across north west London with specific focus on attracting and encouraging staff with research and innovation skills, knowledge, and commitment.
- Develop new measurement to better track the equity of access to clinical trials across our APC.

6.4 Data and digital

6.4.1 **How does this link to guiding policy?**

Data and digital tools are a critical enabler for us to raise standards of care and productivity across the collaborative and promote innovation. To know what to improve and how, we need to know what we are currently doing and how we compare across each other and benchmarked to best practice nationally and internationally. Using common digital tools such as our single electronic patient record, using the NHS App and common dashboards will enable us to measure, compare and provide immediate insights on patient outcomes and our organisational efficiency consistently and transparently. This underpins empowering staff to improve, by giving them the information and insights to encourage their curiosity about their quality, performance, and productivity and how they can learn from and with others across our APC. The scale of our shared infrastructure, including our single electronic patient record, offers enormous innovative potential supporting research and application of leading-edge technologies such as Artificial Intelligence which offer incredible potential to provide higher quality care, greater personalisation of patient experiences and increase staff productivity.

6.4.2 Data and digital will support excellent outcomes and better experiences by supporting patient empowerment, convenience, greater personalisation, and standardisation to best practice. Economies of scale, adoption of innovations such as automation, and best practices to improve productivity and efficiency will create savings. However, we expect that enhancements in analytical capacity and infrastructure will require reinvestment of savings made from digital and other corporate services. Improved digital tools and empowerment of staff to use them wherever they are working will make our APC a much better place to work.

6.4.3 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients are empowered to access, use, and update their information including viewing clinical results, book and change appointments, and finding out about potential research trials that could support their care. They find it easier to communicate with their multidisciplinary team and access information and support that empowers them to manage their condition.
- Partners have access to consistent information across our APC where they interact with pathways, such as patients' readiness for discharge.
- Leaders will have the data they need to improve their services and inform conversations with colleagues and other organisations within our APC.
- Staff are much more curious about what the data shows and are using it to improve their services. They can easily and transparently access up-to-date information across our APC that helps understand where our best practices outcomes, performance and productivity are achieved and how their service or function compares. They find it easy to work across all our sites and access because of the digital infrastructure. Staff will be adopting tools that support their productivity, such as manging patient flow through our organisations and with our partners, ambient documentation, and system generated discharge summaries.

6.4.4 **What are the critical actions?**

- Build common clinical outcome, performance and efficiency strategic reporting solutions that provide transparent, comparable insights and benchmarks from service to site to trust and APC, with real-time functions and interoperable data connections with the systems we use across our APC. Dedicated expertise will be established to work directly with teams to use their curiosity about their data and insights from front-line patient care to measure and improve quality.
- Standardise and enhance our digital applications, infrastructure, data sharing, governance and security, data standards, and data quality across our APC to achieve better quality, staff experience and greater cost efficiency. This should be

anchored around our existing infrastructure of Oracle Cerner electronic patient record, CCS/Federated Data Platform, and the NHS App, and we should aim to move onto the same systems or jointly procure solutions as contracts are renewed wherever possible.
    - Invest and support an on-going programme to optimise Oracle Cerner electronic patient record and its associated ecosystem. This will include scaling best practice training, workflow, and design throughout the system, addressing "paper-based" processes still sat alongside such as some tertiary referrals, and realising the benefits from its installation across our trusts.
    - Develop and deploy the existing CCS platforms to support patient flow, transparent capacity utilisation and further use cases across emergency flow, elective productivity, cancer care, diagnostics and waiting list management.
- Move towards creating collaborative teams that provide high-quality support for systems and infrastructure, support seamless working across sites, and achieve economies of scale.
- Use our digital and analytical strengths to empower patients, promote patient-centred design, staff curiosity and data literacy, and greater equity.
    - Design digital into empowering patient decision making, improving patient experience, supporting equity, and user centred design of best practice pathways. This includes enriching information in shared care records for patient access and joining up with partners, such as the London Care Record, and support to patient-facing tools that make their experience accessing information and managing their healthcare more convenient.
    - Provide training and support to all staff on digital literacy and using our digital tools and applications to their fullest extent to support patient outcomes, analysis, and productivity (e.g., automating tasks).
    - Improve the completeness of information we have about patients such as their protected characteristics by making it easier to share it and use this to inform insights about and improvements in the equity of our outcomes.
    - Expect and encourage all staff to be more curious about data and how they can use it to improve clinical outcomes and productivity.

6.4.5 **How will we measure progress?**

- User adoption and usage of common APC dashboards.
- Reduction in the number of digital systems being used for similar functions and tasks.
- Completeness of data about patients protected characteristics and outcomes.

- Volume of patient transactions such as accessing information or rebooking appointments managed through digital channels.
- Staff feedback on accessing systems irrespective of location, system performance and uptime, responsiveness to enhancement for core systems including Cerner, and whether they would recommend our analytical support and digital support to other colleagues.
- Reduction in the cost per user of IT infrastructure and support.

6.4.6 **Who will be responsible for this?**

- Our digital teams are already working closely together, including joint functions in place between London North West Healthcare and Hillingdon Hospitals, and Chelsea and Westminster Hospitals and Imperial College Healthcare. The Chief Information Officers and their teams will lead improvements across our infrastructure, systems, and support services. Analytical improvements will be overseen by the COOs and CIOs.
- Progress will be assured and tracked by the Digital and Data Working Group chaired by its lead CEO, and our APC Digital and Data Committee.

6.4.7 **What are the immediate next steps?**

- Finalise our data strategy to determine details of approach, standards and investment priorities.
- Established shared, dedicated collaborative expert resource able to develop integrated clinical outcome and productivity dashboards in support of clinical pathway and corporate process improvements.
- Create register of digital applications and systems by function, including their contractual end dates.

6.5 People

6.5.1 **How does this link to our guiding policy?**

High-quality and equitable care depends on our staff. Aligning to best practices across our organisations improves the equity of career opportunities, personal development, experience, wellbeing, empowerment, and engagement our staff. This will support attracting and retaining talented colleagues from our local community and beyond. Our staff will be able to have exciting career opportunities moving between our APC organisations, helping us better connect and share best practices. Savings from reducing unwarranted costs, such as more expensive interim or agency support, can be reinvested

in supporting education, development, and wellbeing, which will also help improve the quality of our care.

6.5.2 Changes in other areas like clinical pathways will impact the people who work for us and the expected impacts on staff have been described in previous sections. We also need to adopt consistent best practices in people policies and processes, including recruitment, onboarding, education, training and development, recognition, reward, wellbeing, and support. Doing so will promote equity and consistency in experiences and enable staff to work and collaborate across our trusts more easily. This supports our vision of being one of the best places to work in the NHS, and addresses our challenge of inequitable opportunities and experiences amongst our staff.

6.5.3 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients will experience higher quality care driven by staff who are happier and empowered in their roles. Increased diversity and equity for our staff, including in senior leadership roles, will support deeper connections with the communities that we serve by employing more people who are representative of our local population.
- Partners will be linked into our training and employment opportunities amongst our local communities as part of our anchor institution responsibilities.
- Staff will have more opportunities to grow their careers and skills without needing to leave north west London. This will include short-term secondments or rotations, collaborative projects, and development programmes. A higher quality staff wellbeing offer will support our people to be happier and thrive at work.

6.5.4 **What are the critical actions?**

- Align all our people and employment policies and processes to best practice so that staff are treated and supported fairly, consistently, and equitably.
    - Agree shared policies and approaches to creating policies across all people policies (leave, flexible working, etc.), bullying, harassment, discrimination and violence, disciplinary and performance management.
    - Establish a unified recruitment and onboarding process, with recruitment to posts where possible from within our APC to encourage succession planning, talent development and promotion opportunities from within our APC.
    - Implement improvements so that everyone finds it easy and seamless to work across sites and trusts. This includes easy access to apply and join

shared bank, skills and mandatory training passport, honorary contracts automatically in place to visit other sites, and making it easier for individuals to work and support short projects or needs across organisations.

- Implement our equity, diversity, and inclusion action plan to support fairer and more just employment practices and outcomes.
    - Create dashboards transparently sharing employment outcomes across our APC to learn, share and support alignment to best practice.
    - Implement best practices in recruitment, induction (with particular focus on international recruits), reasonable adjustments, bullying, harassment, discrimination, and violence.
- Increase the breadth and quality of our education and training programme opportunities for our staff by sharing access and best practices.
    - Allow staff access to education and training programmes already happening across our APC to support connections between our organisations and increase consistency of practice.
    - Where we offer similar training schemes, identify the best practice training approach based on staff development outcomes and their feedback, and scale these as standard best practice across our APC.
    - Create common skills, knowledge, and experience passports for our staff to track, evidence and plan their education needs across our APC.
    - Increase the number of joint APC programmes for learning and development, using our collective buying power and influence, including to address skill gaps and support apprenticeships for new and existing workforce roles.
- Identify the best practices across our APC that support staff wellbeing, employment and health and invest in scaling these across our APC. This could include digital tools, support for staff mental and physical health, supporting staff communities and networks, and dedicated support for international recruits.
- Develop best practice talent management functions to proactively and equitable identify high performers across organisations, provide pairing, coaching, mentoring, and sponsorship opportunities to develop network and career moving within and across APC organisations.

6.5.5 **How will we measure progress?**

- Staff who would recommend our APC as a place to work.
- Average staff vacancies, turnover and sickness.
- NHS Staff Survey score for diversity and equity.

- Staff in senior band, VSM and consultant medical roles reflect the diversity of our local community.

6.5.6 **Who will be responsible for this?**

- Our Chief People Officers are jointly leading a Scaling People Services programme which has been conducting deep and broad engagement and co-design since 2023. Their progress will be overseen by the People and Inclusion workstream chaired by its lead CEO, and assured by our APC People Committee.

6.5.7 **What are the immediate next steps?**

- Implement the immediate priorities agreed through our Scaling People Services programme and Equity, Diversity, and Inclusion Action Plan.

6.6 Estates and sustainability

6.6.1 **How does this link to our overall response?**

The experiences and quality of care experience by our patients, the daily working life of our staff and their productivity, and significant local impacts such as our sustainability all depend on our estate. Across our collaborative, we have a larger physical footprint than the Pentagon. Within the three-year timeframe of our strategy, we are not planning for significant differences in our estates beyond progressing major hospital rebuild programmes. However, we will align our best practices across our organisations in how we use, maintain, and enhance our physical assets while learning from shared, transparent information to support higher quality care, better staff experiences, and leverage our buying power as a Collaborative to reduce costs.

6.6.2 There are numerous ways that aligning best practices in estates and sustainability supports improvements in quality, efficiency, and staff experience. This includes:

- Sharing best practices in the thoughtful use and redevelopment of our buildings, sites, and spaces to support patients, widen access to community spaces and support the local economy as anchor institutions.
- Implementing our Net Zero plans to reduce our environmental impact, including saving costs from lower energy utilisation.

- Procuring, designing, and assessing our estates and facilities to support better facilities for staff and patients and more effective use of our limited resources, in particular ensuring our services are accessible to all.

6.6.3 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients visiting our buildings will find them to be more accessible and easier to use, access, and attend services.
- Partners will see improvements in our hospitals' efficiency and sustainability, showing real differences in carbon emissions and a more joined up approach to facilities contracts. Our hospitals will be using more local suppliers, supporting our local economy. Local communities will benefit from wider access to our facilities and spaces to support local health and wellbeing.
- Staff will see improvements to their facilities and working environment with a consistent offer across our APC. It will be easier to work between hospitals with the same or similar facilities and estates processes in place.

6.6.4 **What are the critical actions?**

- Develop shared best practice standards in staff facilities and agree a common approach to deploy our routine maintenance investments to ensure quick enhancements towards these standards that staff recognise as beneficial.
- Assess where we can get most value from shared services for estates and facilities contracts (e.g., where there is significant variation or specialty services). This could include inpatient catering, linen/laundry, and non-emergency patient transport.
- Develop a shared view of carbon emissions and other environmental impacts such as landfill waste across trusts with regular reporting and greater transparency. Share and scale successful local sustainability initiatives and adaption plans to accelerate our progress on reducing our environmental impacts and being better prepared for a more uncertain climate.
- Develop greater understanding of vacant or 'under-used' estate and our utilisation of our physical assets to make best use of this as a collaborative, such as supporting innovative clinical pathways and services supported by staff working across our organisations.
- Incorporate social value and anchor institution responsibilities into re-development planning, and share our learning and expertise from recent major redevelopments, such as the community diagnostic centres.

6.6.5 **How will we measure progress?**

- Assess the accessibility of our estates.
- Staff feedback on the quality of their working environment and facilities.
- Tonnes of CO2 emitted – whether we are on track with reducing our CO2 emissions in line with our carbon budgets.
- % vacant or 'under-used' estate.
- Total Hard FM and Soft FM costs per m^2.

6.6.6 **Who will be responsible for this?**

- The executive strategic estates and sustainability group chaired by its lead CEO will be accountable for this work, reporting to the Strategic Estates and Sustainability Committee.

6.6.7 **What are the immediate next steps?**

- Develop a shared approach for our NHS Carbon Footprint data and measurement.
- Share and spread initiatives that have shown demonstrable benefit to carbon and financial savings (an example of this would be around the PC Power-down solution implemented at Imperial in early 2021 now spreading to the other trusts).
- Share learning of approach to Green Plan across trusts (an example would be in application for Public Decarbonisation Grants and large-scale nitrous oxide waste mitigation).
- Align our approach to collecting and sharing estates and facilities data and understanding where there are opportunities to align contracts.
- For areas of high variation in estates and facilities, work to align approaches across the collaborative.

6.7 Other non-clinical and support services

6.7.1 **How does this link to guiding policy?**

Effective non-clinical and support services enable excellent outcomes by ensuring our staff have everything they need to care for our patients.

6.7.2 Standardisation of corporate workflows, systems and processes will simplify future opportunities to rapidly scale best practices that will improve outcomes for patients and staff, whilst also supporting greater resilience and sustainability across our APC. Cost efficiencies achieved through adopting best practices will help address our underlying deficit and be re-invested in further improvements and enhancements to digital and analytical capacity.

6.7.3 **What will be different for patients, partners, and staff in 3-years' time?**

- Patients will notice happier staff who have the tools and support they need to do their work more effectively. They will find it easier to communicate with our organisations and find out information about our services.
- Partners will experience greater consistency in working with trusts such as when planning future workforce and education needs across north west London, and in some instances may work with one person or team representing on behalf of our APC.
- Staff will experience high-quality support from corporate services and systems, which are more efficient and cost-effective. This will make it easier and quicker to answer questions about their employment or support they need, replace or order supplies they need to provide best practice care, and get estates and facilities issues fixed more quickly. Staff in corporate service teams can expect to have access to consistent knowledge and skills, making it easier to move across sites and share best practices.

6.7.4 **What are the critical actions?**

- Embed and realise benefits including cost efficiencies from existing joint programmes, including procurement, payroll, transactional financial services, and scaling people services.
- Across other corporate and non-clinical function, review current policies, processes, and procedures to prioritise where there is the greatest opportunity in improve performance and cost effectiveness from alignment to best practice. We anticipate the priorities to be where there are:
    - Areas where there are known performance and productivity risks or gaps from external best practice benchmarking.
    - High-volume and highly standardised corporate areas where economies of scale could offer significant gains in efficiency and productivity.
    - Areas that require specialised knowledge or skill so that having one aligned and unified best practice approach will reduce the need for outside expertise or advice.
- Develop consistent approaches to transparent information sharing and reporting across corporate services to enable improved planning and robust evaluation of outcomes, including the efficiency and productivity of any support at each location to identify best practice and improvement opportunities.

6.7.5 **How will we measure progress?**

- Reduction in the average costs of support services.
- Reduction in errors or issues in the service (e.g., for payroll a reduction in overpayments).
- Increase in responsiveness and turnaround times of corporate services.
- Increase in staff who would recommend the support they receive from our corporate services.

6.7.6 **Who will be responsible for this?**

- Executive leadership of our corporate functions will be responsible for directing the collaborative work across their teams.
- The Finance and Performance Workstream and its lead CEO will be accountable for the improved performance and cost of corporate and non-clinical functions, reporting into our APC Collaborative Finance and Performance Committee.

6.7.7 **What are the immediate next steps?**

- Continue implementing agreed priority initiatives.
- Agree priority areas for improvement from the second half of this financial year.

6.8 Anchor institution responsibilities

6.8.1 **How does it link to the guiding policy?**

As the largest single employer in north west London, we are also committed as anchor organisations, meaning we have an important presence in our local places, to support local economic development, wellbeing, and improve the health of north west London. We will align how we work together to best deliver on our ambitions as anchor institutions. These include ensuring more local recruitment from our local communities, including expanding apprenticeships, using collective buying power to support local businesses, and working closely with local organisations to share expertise and building our understanding of needs to support population health and wellbeing.

6.8.2 These actions support higher quality and equitable care as we engage with communities and support population health outcomes. Improved recruitment from our local communities and collective use of our buying power will help us use resources more efficiently.

6.8.3 **What will be different for patients, partners, and staff in three years' time?**

- Patients will have access to care and specialist expertise connected into their neighbourhoods. Numerous care pathways will have been redesigned to effectively promote population health outcomes and sustainable health improvements, not just effective treatments to sickness.
- Partners will find it easier to work with APC organisations as they can quickly reach an appropriate local contact when the context of their need is local, or a single, shared voice when the context is regional. Local partners will have their voice heard more within our APC.
- Staff will have personally rewarding opportunities to connect and support their local community, such as encouraging aspiration within local schools or leading engagement with local community, voluntary and faith groups.

6.8.4 **What are the critical actions?**

- Identify and align best practices in meeting our anchor organisation responsibilities, in areas including education, employment, economic development and sustainability. Determine whether best practice can best be best achieved working once across our APC or locally with different partners, and implement the steps needed to achieve this.
- Share and standardise our approach to partnership working within each trust, while each trust retains independent local leadership and relationships.

6.8.5 Potential measures of progress

- Proportion of non-pay expenditure conducted through north west London businesses.
- Number of apprenticeships supported and new staff recruited who have home address in north west London.

6.8.6 Who will be responsible for this?

Each trust has organised its external collaboration and engagement functions differently. Progress in this area will be overseen by collected group of Strategy and Communication directors, who will be responsible for coordinating and facilitating connections across our organisations and tracking best practice with updates shared with our APC Executive Management Board. Our anchor institution responsibilities will be overseen our APC People and Inclusion workstream and its lead CEO, because of the importance of local employment, reporting to our APC People Committee.

6.8.7 What are the immediate next steps?

- Conduct a discovery exercise on existing anchor responsibility strategies and initiatives across each APC trust and share this best practice.
- Agree priority areas and initiatives to align best practices from the second half of the financial year.

7. Measuring our progress

7.1 Data and information will be central to all our improvements. When addressing a challenge or considering potential improvements, we will first agree the outcome measures that will demonstrate whether any changes we make are an improvement. We will then align to the best practices that achieve these outcomes. For each initiative or improvement effort, demonstrating increases in the average outcome measures and the equity of this outcome will be our evidence of progress.

7.2 We have also prioritised a small number of outcomes to help us understand and track whether our response and efforts are supporting progress towards achieving our vision. These outcome measures have been chosen because they collectively measure patient clinical outcomes, access to services, productivity, and staff experience. They can also be used at every level from across our APC to individual trusts, each site and into individual services and teams. Supporting these metrics, collaborative teams and improvement initiatives will need to set out the important supporting metrics in their area where progress and improvement is needed. Improvements in these metrics will contribute to progress in these prioritised measures and mitigate risks of perverse behaviour and incentives from having too narrow a focus on simple metrics in a complex system.

7.3 Irrespective of the metric and whether it is from this strategic list or a supporting area, we will judge success only when we see these measures improve across our APC and simultaneously having a smaller range between each of our trusts. This is because we are committed to raising standards so our median performance goes up, and more equitable outcomes across our organisations meaning ranges between the highest and lowest performing trusts should go down.

7.4 Our recommended measures to track overall progress and success of our strategy are:

Outcome	Rationale	APC median	Range (scores of the highest and lowest performing trusts)
% of friends and family who would recommend the care they received	Our core purpose is caring for patients, and this measure reflects their feedback on our quality	95.7% *April 2024*	ICHT – 96.2% THH – 94.5%
% of staff recommending the care provided by their organisation for their friends and family	Our staff know our services better than anyone, and this measure reflects their confidence in what we provide	66.0% *2023 National Staff Survey*	CWFT – 77.08% THH – 52.52%
Standardised Hospital Mortality Index	Safety and effectiveness are at the heart of quality. This measure benchmarks our care	0.80 *Feb 23 to Jan 24*	CWFT - 1715/2435 - 0.7 THH - 905/940 - 0.94
% of people admitted, transferred or discharged from A&E within 4 hours	Swift access to urgent and emergency care supports better clinical outcomes and patient experiences	78.0% *April 2024*	CWFT – 81.7% ICHT - 76.2%
Number of people waiting more than 52 weeks from referral to treatment for planned care	Long waiting times are significant driver of current public dissatisfaction with the NHS and a nationally agreed priority to improve. Reductions are only possible through combination of higher quality care, productivity and expanding our capacity by being a great place to work. Over the next three years, this waiting period will come down towards the 18-week NHS Constitutional Standard.	Total: 9819 patients *April 2024*	LNWH – 4193 patients THH – 492 patients

% of patients treated who have been recruited into a clinical trial over the last 12 months	Expanding access to clinical trials supports improve care quality and equity	*New measure to be developed*	*New measure to be developed*
% staff recommending their organisation as a place to work	We are committed to be the best place to work in the NHS and this is a direct measure of our progress	63.38% *2023 National Staff Survey*	CWFT – 70.07% THH – 52.53%
Cost per Weighted Activity Unit	This measures whether we are aligning to best practice in productivity and cost efficiency	98.5% (Cost Weighted Activity @ m10)	CWFT – 103% LNW - 93%

7.5 These priorities strategy measures will be reported to every board-in-common to track quarterly progress. We will create automated dashboard that will allow ward-to-board exploration of performance of each of these strategy metrics to understand our progress and variation.

8. Making it happen

8.0.1 Implementing this ambitious approach successfully is not just about the specific actions we take, but the support structures, values, behaviours, and ways of working that will help us effectively tackle unforeseen challenges and opportunities. Our strategy is a commitment to think and act differently through our work together. Change is difficult but will be more likely to succeed with reinforcements and role models.

8.1 Conditions for success

8.1.1 For our strategy to be successful we will need to make sure we have support structures including the organisational development and technical change skills across our organisation, be able to transparently use our data to support improvement and evolve this in an agile way to respond to curious questions, and support closer, central coordination across our four trusts to drive out variation rather than encouraging it to flourish.

8.1.2 **Organisational development and technical change skills:** Change is difficult and requires skills and knowledge. Our collaboration depends on existing and new teams and networks working in new ways. We will prioritise the organisational development capacity that will help strengthen and improve the cultures, behaviours, mindsets, and ways of working that enable sustainable change.

8.1.3 Our staff need to be able to connect and network with counterparts across our organisations. These may be people in similar roles, or people determined to make improvements in similar areas. Our organisational development support will need to make these connections easier so that networks of expertise and interest can grow and connect across our 33,000 staff. We will learn from other multi-site, geographically distributed organisations as we recognise this is a new challenge for us.

8.1.4 We believe people working together on improvements is one of the best ways to build trust, understanding, and teamwork. Our approach invites and expects staff to connect across teams and organisations to work together identifying areas for improvement and implementing best practices. However, new teams do not always work well together immediately. Teams working across independent organisations will need to rely less on hierarchy. Our organisational development support will be updated to provide training on forming high performing teams, routines to support effective communication and accountability, and managing disagreements across peers.

8.1.5 Complementing this organisational development capacity, we will prioritise upskilling and support on technical improvement skills within team in collaborative training programmes. This will create new connections, networks, and support us adopt the best practice training and tools that lead to effective, sustainable, inclusive change. This will help strengthen cross-APC team performance as they will use the common tools and principles for collaborative improvements, avoiding delays from having to agree which individual organisation's approach or template is the right one or duplicating outputs.

8.1.6 Senior leaders and managers will also be supported to change their mindsets, behaviours, and ways of working as role models for our collaborative approach. This will include training to provide more coaching and mentoring that empowers their teams use the data, share openly with others, and apply their creativity to improve outcomes. They will be supported to encourage decision making as close as possible to the patient, even when working and standardising across our organisations, to avoid every change being bottlenecked by multiple layers of governance. We need these changes to support a broad movement for improvement that harnesses our collaborative talents and resources.

8.1.7 **Using data:** Our approach is underpinned by transparency. This is led by data that is available and analysed across organisations. It is complemented by a commitment to openness with peers, rather than being defensive or protective. Given the importance of the data and information sharing, dedicated capacity to develop shared dashboards on common infrastructure is vital and will be prioritised. How our analytical teams work with services will also change. Our analytical teams will need to work with teams focused on improvement to agree the priority outcomes, how they can be effectively measured through our clinical and data systems, where we may need to make compromises, and then quickly build something useful that visualises these metrics and can be automatically updated. This is different to static information requests being sent to information teams.

8.1.8 We have set finalising our data strategy as an immediate priority. Any dashboards will need to be scalable and shareable across our APC. This means that as we develop priority outcomes to support a service improve, we will always seek to compare this across our organisations, be able to measure in greater detail by sites, individual teams, and clinicians, and incorporate external best practice benchmarks when these are available.

8.1.9 The potential demand on creating insights and dashboards like this though could easily exceed our available capacity. This means that we need complementary ways of working that support our teams access and use our information. We will create common, shared dashboards and data environments where teams can build their own views and

access information themselves without needing specialist analytical resources. This means that we must also train and support our clinical and operational teams on how they can use analytical skills to understand problems, develop improvement ideas, and act on insights. We will share best practice in ways of visualising and tracking improvements, such as statistical process control charts. This supports us have common, shared training approaches and makes it easy for multidisciplinary teams to quickly understand new dashboards. We will also train staff to make full and effective use of national and regional data tools, such as Model Hospital and the FDP/CCS solutions.

8.1.10 Dashboards and information will also be more accessible to teams as they work to help them understand their real-time performance. We already use large screens in clinical areas to support operational flow and decision making, such as the Timely Care Hub dashboards. We will expand this way of working to help teams track improvement and alignment to best practice in real time.

8.1.11 Putting these improvements in how we share and use data also requires a change in the expectations of our staff. We believe that when given better access to useful information, our staff will apply their inherent curiosity and creativity to improve services and outcomes. This change in how we work will create virtuous cycles where new outcome measures and innovations identify and create new possibilities to further raise our standards. Alongside expecting these changes, our leaders will need to role model using this information and hold our teams to account in how they are applying it to improve services.

8.1.12 **Coordinating progress:** We have prioritised aligning best practices across four sovereign organisations. This means everyone's role includes responsibility for collaboration, transparency and sharing. With a broad, ambitious programme we need to be able to analyse and track progress, identify risks, delays, and potential interdependencies, and prioritise targeted interventions. We will align programme and project management approaches to the best practices in our APC to give consistent, clear, and concise information on each area. Our resources are constrained so we will agree how we can best collaborate across organisations to support this synthesis efficiently and effectively. Progress will be reported each month to our APC Executive Management Board. This will also support peer accountability between organisations on progress and how we are meeting our shared commitments.

8.2 Values, behaviours, and ways of working

8.2.1 The guiding policy of raising standards by aligning to best practice emphasises continuous improvement, collaboration, and seeking the highest standards of care. By striving for a culture of excellence and innovation, we ensure that our organisations consistently achieve the best outcomes for patients, build efficient partnerships, and provide a supportive work environment for staff. Achieving these outcomes is dependent on the quality of team working and team climate.

8.2.2 While each APC organisation will maintain its own culture and values, we collectively embrace a clear shared vision and APC values of curiosity, openness, transparency, and excellence. We are committed to changing how we solve problems. When we come across an issue, challenge, or risk within an organisation, we will first explore how others in our APC have solved it, the outcomes they achieve, and what we can do to align to best practice. When agreeing best practices, we will anchor on patient and community needs, not institutional needs, knowing we can address these collaboratively together. This shared APC culture layered into our trust cultures will support the movement for change and improvement described in our approach.

8.2.3 Recognition and future career development within our APC will be linked to exemplifying these values and ways of working. Other actions we will implement to promote these shared APC values and behaviours include:

- Introduce consistent communication and messages across our APC, such as regular all-staff meetings and digital communications promoting APC programmes, opportunities, and successes.
- Establishing rotational posts around and across our APC to expand colleagues networks, skillsets and experiences, whilst drawing together shared ways of working and common values.
- Creating clinical and staff community networks to grow connections and share best practice across our APC workforce in areas that matter most to people.

8.3 Risks and their mitigations

8.3.1 ***Deploying dedicated resources to support this strategy***

The progression of implementing strategic objectives could be delayed by resource availability, upfront investment, and compatibility with on-going programmes. These

challenges can be mitigated through assurance and governance structures tracking progress and supporting prioritisation, the ability to learn and adapt, and redeploying existing staff from lower value individual trust programmes to higher impact collaborative programmes.

8.3.2 ***Industrial/operational disruption***

There is a risk that industrial action or operational pressures could distract from long-term strategic change and improvement, preventing staff from engaging and participating. To mitigate this, a primarily bottom-up approach that remains relevant and aligns with best practices can save time by reducing duplication and interdependent designs. Additionally, a broad approach allows for the involvement of many people.

8.3.3 ***Changes in national priorities***

Trusts have multiple collaborative arrangements with other providers and wider partners, each with differing demands. Shifts in national and local policy may require rapid adjustments, disrupting ongoing initiatives. The core of the strategy is to align with best practices, ensuring relevance in addressing external requirements. The strategy was developed with a clear diagnostic that anticipates likely demands, and is aligned with the North West London ICS Joint Forward Plan.

8.3.4 ***Availability of resources and investment***

With limited resources and investment, there's a risk of overextending resources during the transition phase, which could strain existing systems. To mitigate this, rolling out collaborative initiatives in phases will prevent overwhelming capacity for change. Establishing clear metrics to monitor the impact of the collaborative strategy on care quality, resource utilisation, and financial performance can effectively support strategic priorities.

9.Conclusion

8.1 Our strategy sets out a clear vision for the way that we work together as an Acute Provider Collaborative. Our guiding policy will support us and our partners to make sure residents experience the same excellent quality of care regardless of where they receive it, and make sure that the Acute Provider Collaborative is one of the best places to work in the NHS.

8.2 This strategy supports each of our trusts to work towards the shared priorities outlined in their individual strategies, including a focus on quality of care, equity, sustainability, and our people, and outlines how we are going to work together as a collaborative to accelerate our progress.

8.3 The co-creation of this strategy demonstrates how far we have come, and we express our gratitude to everyone who has been involved in its development.