London North West Healthcare NHS
NHS Trust

2016-2017 Annual Plan

Draft Final Submission 30th March 2016

(LNWHT Annual Plan 1617 v5.docx)

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1 Background

1.1 This is the second annual plan for London North West Healthcare NHS Trust (LNWHT) following its establishment on 1st October 2014. It marks a year of consolidation during which substantial progress will be made towards creating a clinically and financially sustainable organisation. Next year will also see the completion of three critical exercises to plan for the future, namely:

- A comprehensive reassessment of the Trust's clinical strategy
- An organisational development programme to support our journey to becoming an excellent integrated care organisation, and
- Engagement with our staff, partners and service users to set out an ambitious vision for the Trust and the values and behaviours to achieve this.

1.2 The focus of the annual plan is rightly on improving clinical service quality and access. These goals will be supported by improvements in business intelligence systems. We will also continue to work with the SaHF programme to address estates challenges. Corporate functions will also be unified and streamlined to allow them to better support front line services.

1.3 Governance arrangements have been strengthened to support the wide-ranging programme of transformational change that is taking place.

1.4 Divisional priorities

1.5 Detailed divisional plans underpinning the annual plan submission were presented at a one-day Board workshop on 14th March. These plans are shaped by the Trust's overarching priorities:

- To address quality and safety issues highlighted by the CQC (findings and recommendations from the October 2015 inspection are still to be published)
- To maintain and improve our focus on key National access standards, the delivery of our financial recovery plan and control total, and
- To integrated clinical services across acute and community settings.

1.6 The Trust plays a vital role in northwest London's healthcare strategy: Shaping a Healthier Future (SaHF), and divisions will evolve to support the sector's ambitions to improve access to and outcomes from healthcare. Ealing Hospital's transition to a local hospital model will take a further step in 2016/17, with the reconfiguration of paediatrics.

1.7 Note on the draft final plan

1.8 Contract negotiations for 2016/17 have yet to be concluded following the receipt of formal contract offers from the Trust's main CCG commissioners on 11th March. At the time of writing, the level of QIPP and growth is still being negotiated. Significant progress has been made towards agreeing activity volumes and financial assumptions. Some uncertainty will remain until negotiations are finalised.

1.9 Version 5 of the annual plan as presented is based on an indicative £61.5m deficit budget for 2016/17 in line with the NHS TDA Control Total and assumes a £21.5m Sustainability and Transformation Fund allocation. Indicative budgets for 2016/17 are being finalised on this basis.

1.10 Finance, activity and workforce plans included in the 11th April submission will necessarily reflect best-estimates available at that time, but are not expected to differ materially from the control total assumption.

2 Activity plan

2.1 A first draft activity plan was submitted to the TDA on 8th February. The 2016/17 plan is derived from 2015/16 activity adjusted for growth, seasonal effects, service developments, national planning assumptions and best estimates determined from trend analysis. An updated activity plan will be submitted for the April submission based on the latest position on contract negotiations.

2.2 Commissioning principles and intended service developments were shared with commissioners in December. Activity baselines at POD and CCG level have been agreed with commissioners. Further work is underway to cost at HRG level. Demographic growth has been agreed and non-demographic growth estimates are under negotiation. QIPP schemes have largely been agreed by the Trust, subject to the contract form not penalising the Trust in the event of non-delivery of the QIPP. Trajectories for the four key targets are under discussion and these may have an impact on activity levels once agreed.

2.3 Capacity and demand modelling

2.4 Detailed analysis of capacity and demand for all Trust services and sites has been carried out as part of the 2015/16 recovery drive, SaHF business case development and ongoing recovery planning. Aligning medical capacity to demand across all specialties has been a priority, to support the maximisation of productivity. Robust models have also been created for diagnostics, theatre utilisation and non-medical clinical staffing. NHS Intensive Support Team methodologies have been applied to the analysis and modelling of waiting lists for endoscopy and radiology.

2.5 The initial approach taken estimated demand based upon current activity adjusted for growth and the clearance of backlog waiting lists. This will be refined as commissioning assumptions are clarified and outputs aligned to the final activity plan. The aim is to ensure that the Trust plan has sufficient capacity to meet agreed activity and to ensure that any use of the private sector is short-term and addresses exceptional issues.

2.6 Outputs of capacity and demand analysis has also informed divisional plans to ensure internal consistency and reconciliation to the overall Trust plan.

2.7 Throughout 2015/16 the Trust has been monitoring trajectories across services, with particular focus on the performance of A&E, 18 weeks referral to treatment, cancer and diagnostics. The Trust has agreed with CCGs additional non-recurrent system resilience funding within 2015/16 to support core demand across the Trust.

2.8 Improvement Trajectories for the delivery of national targets

2.9 Trajectories for key national standards in 2016/17 submitted by the Trust on 4th March are summarised in Discussions are on-going concerning the assumptions and modelling methodology used to predict the financial, activity and workforce implications of the improvement trajectories.

2.10 Notably, the Trust achieved a step-change improvement in A&E four hour waiting times as the new modular bed capacity came on stream in January 2016. Allowing the 95% standard to be achieved on a number of days in January and early February, which marks a major milestone and is the culmination of considerable and sustained efforts by front line staff.

2.11 Table 1. Subsequently, extensive work has taken place between the Trust and CCGs to agree and finalise these trajectories. Discussions are on-going concerning the assumptions and modelling methodology used to predict the financial, activity and workforce implications of the improvement trajectories.

2.12 Notably, the Trust achieved a step-change improvement in A&E four hour waiting times as the new modular bed capacity came on stream in January 2016. Allowing the 95% standard to be achieved on a number of days in January and early February, which marks a major milestone and is the culmination of considerable and sustained efforts by front line staff.

Table 1 2016/17 improvement trajectories (4th March 2016)

Access Standard	National Standard	Trust Baseline April 2016 (est.)	Improvement Trajectory
A&E four hour waiting time	95%	90.5%	Maintain 92% from July 2016
Referral to Treatment (RTT) incomplete pathways	92%	89%	92% from July 2016
62 Day cancer waiting times	85%	85%	Maintain 85%
Over 6 week diagnostic waiting times	99%	98.2%	99% from July 2016

2.13 Assumptions underlying the Trust's submissions are set out below. All are reliant on support from CCGs as part of the commissioned 2016/17 contract and Systems Resilience Group (SRG) planning.

2.14 The A&E baseline is set on the recent Unify planning assumptions for 2016/17. This is based on 2015/16 month1-6 SUS "times two", with 3.1% growth applied.

2.15 The referral to treatment (RTT) baseline in the plan is based on March 2016 year to date activity and performance including year-end improvement trajectory. 2016/17 plan aligns to 3.1% growth.

2.16 The cancer 62 day baseline is set on the Unify planning assumptions for 2016/17 which was calculated using 2015/16 open Exeter Q1&2 "times two" to give a projected forecast outturn of 863 total cancer 62 day waits. A growth of 9% has been applied based on the average growth seen across tumour sites as issued by the Transforming Cancer Services guidance for 2016/17 planning.

2.17 The diagnostics baseline is set on the recent Unify planning assumptions for 2016/17. This is based on 2015/16 month1-6 DM01 "times two" with 15% growth applied to endoscopy and 12% applied to non-endoscopy diagnostics, this is based on 2016/17 planning guidance for Transforming Cancer Services.

2.18 Assessment of activity over the next year

2.19 Commissioners supported the Trust throughout 2015/16 by targeted investments of system resilience monies to address instances where demand significantly exceeded funded capacity; and providing:

- Additional acute medical beds to care for medically fit for discharge patients awaiting the completion of CCG and Local Authority placement processes
- Additional community rehabilitation beds to support acute flow and maintain the delivery of patients' recovery goals outside of an acute setting, and
- Outsourced diagnostic endoscopy activity to support the management of 18 weeks referral to treatment (RTT) and diagnostics pathways.

2.20 A key priority for the Trust in 2016/17 is to ensure that agreed activity plans are realistic in their estimates of demand and staffing, and robust with respect to the delivery of milestones linked to operational standards. Detailed analysis and testing of plans, with a particular focus on the delivery of agreed trajectories for accident and

emergency (A&E), RTT (incomplete), cancer and diagnostics access standards is underway and remains to be completed.

2.21 Service developments

2.22 Proposed pathway improvement and service development priorities summarised in Table 2 and Table 3, respectively, were shared with commissioners in December 2015. These align with the five Trust objectives adopted prior to the merger:

- Improving our focus on quality and safety
- Improving patient experience, satisfaction and engagement
- Creating a sustainable workforce that is lead and engaged in developing and improving services
- Ensuring financial stability, and
- Planning for our future.

2.23 At this stage, and pending agreement with commissioners, no associated costs are included in the draft financial plan. This being a prudent view.

Table 2 Key service improvement priorities (proposed)

Pathway	Objective
Emergency care	Following commissioning of additional beds in November 2015, the total bed-base will be remodelled as part of an "acute flow" programme to redesign of the patient pathway, improve patient experience and care delivery, and support the achievement of A&E standards.
Elective care services	Capacity and demand analysis undertaken in 2015/16 is the basis of a series of transformational initiatives aimed at achieving RTT standards. Projects targeting the streamlining of outpatient services and diagnostic pathways (under the banner of "completing today's work today") will be complemented by a theatre utilisation programme to increase productivity and efficiency.
Cancer services	Further integration and alignment of cancer pathways aims to underpin the Trust's role as a major provider of cancer diagnosis and treatment, using service and process redesign to enhance patient experience, reduce the need for out-of-sector treatment and reliably achieve national standards.
Diagnostic services	The aim is to transform practice to mitigate the twin trends of rising diagnostic and imaging demand resulting from the drive to shorten pathways and strong underlying demand-growth that has consistently exceeded plan projections.

Table 3 proposed service developments for 2016/17 and divisions responsible for their delivery

Medicine	Surgery	Integrated Clinical Services
1) Critical care and high dependency unit beds 2) Memocath stents 3) Rheumatology & haematology helplines	4) Virtual fracture clinic 5) Sacral Nerve Stimulation for the Bladder 6) Inflammatory Bowel Disease Telemedicine Clinic 7) ENT voice clinic 8) LA Diode laser ablation of bladder tumours 9) Transanal submucosal endoscopic resection	10) Penile Rehabilitation clinic for prostate cancer patients 11) Upper Tract Hexvix 12) Thyrogen Injections
13) Telephone access to consultant opinion for GPs 14) Virtual clinics		

2.24 The expansion of critical care capacity (reference 1, above) is the Trust's most important proposed development for 2016/17. An independent review has confirmed that a significant gap exists between bed capacity and demand. Pending a long-term solution, which will involve approval of a major capital case, the Trust intends to increase critical care capacity from 27 to 64 beds. This would also support the provision of dedicated paediatric high-dependency beds.

2.25 Innovations in providing virtual, online and telemedicine clinics and advice lines, aim to benefit patients by reducing the number of visits to hospital, shortening waiting times and making more efficient use of resources. As well as enabling primary care professionals to access clinical advice, allowing hospital outpatient and A&E attendances to be reduced. Skype clinics in radiology will be used to test the efficacy of this established online communication channel.

2.26 Other service developments, such as sacral nerve stimulation and Hexvix, aim to provide an alternative for patients and their families and carers, who currently have no choice but to make a long journey for diagnosis or treatment.

2.27 The Trust also strives to provide service users with access to treatments and new technologies that have not previously been available, but that have been proven to improve clinical outcomes and patient experience, such as improved rehabilitation for prostate cancer patients. Some, such as laser ablation and endoscopic resection, bring additional efficiency benefits by reducing lengths of stay and in some cases allowing day case treatment.

2.28 Proven technological advances are also adopted where these provide significantly improved life-time outcomes, such as the use of longer-lasting stents.

2.29 A further proposed development for 2016/17 is the expansion of manufacturing capacity within pharmacy to cater for increased demand for parenteral feeding. This will also benefit patients by enhancing the scope for community-based care.

2.30 Managing unplanned demand

2.31 Additional system resilience capacity as part of planning for winter 2016/17 is in the process of being agreed through the local System Resilience Group. This forum will also co-ordinate commissioners' in-year funding response to unplanned changes in demand.

2.32 Key components of the Trust's contribution to sector resilience include:

- A contingency capacity of 48 general and acute beds that became operational on 18 January on completion of the modular build at NPH
- Contingency capacity the Trust was able to provide over the winter of 2015/16 included 12 medical beds at EH, 20 step-down beds at CMH and 5 community rehabilitation beds at Clayponds in Ealing
- Currently there is no scope to expand adult critical care capacity beyond the 27 beds at NPH and 9 beds at EH, or the 28 neonatal intensive care cots at NPH
- Urgent care centres located on NPH, CMH and Ealing sites
- Community rehabilitation capacity at Willesden Community Hospital, CMH (since January 2016, having been formerly provided in the Denham Unit) and Clayponds Hospital
- Home-based and community nursing and therapy capacity including intermediate care and rapid response services, and
- Mortuary refurbishments completed in December 2015 increased body storage capacity at CMH by 36 at CMH and 12 at NPH.

3 Quality plan

3.1 Clinical governance framework

3.2 Revised Board assurance arrangements were put in place during 2015/16 under which oversight of quality takes place through the Integrated Governance Committee of the Board and the two reporting executive committees for Clinical Quality and Risk (chaired by the Chief Operating Officer), and Corporate Quality and Risk (Chaired by the Chief Financial Officer). The executive lead for Quality and Risk within the Trust is the Chief Nurse.

3.3 The structure of the governance and risk functions will continue to be redesigned in 2016/17 in support of delivering merger synergies arising from the alignment and streamlining of corporate and clinical support processes and functions. Clinical governance and risk will continue to be devolved to divisions, with divisional governance coordinators maintaining risk registers overseen by divisional Quality and Risk Groups that feed into the executive and board reporting structure.

3.4 Divisions' own governance frameworks were reviewed in 2015/16 which included the creation of clinical governance and audit leads in each division. These roles have been fundamental in the divisions bringing together the relevant clinical performance data for review by the divisions and validation into the Trust governance processes. This has facilitated learning from clinical audits, complaints, Datix, SI's, patient feedback and operational performance.

3.5 The Trust has improved its responsiveness to complaints over the last 12 months with increased emphasis on the timeliness and quality of response and again this is a key aspect of review at the divisional performance review meetings as well as more assertive follow-up from the central complaints team.

3.6 Incident reporting and lessons learned

3.7 During the last year the Trust has identified deficiencies in the current process of reporting and learning from serious incidents (SI's) and Datix reports. In response the Trust has re-issued guidance to staff on the need to comply with the incident reporting policy, ensured that there is monthly discussion of incident reporting, investigation and timely closure of reviews at the divisional performance review meetings. It has also improved its reporting of Datix incidents and the closure of investigations to the Board and its sub-committees.

3.8 The Trust has revised the serious incident policy and put in place a fortnightly executive review of SI progress and report findings before these are formally accepted and signed off. It is also developing a plan to ensure there is a more comprehensive and robust system in place to develop a culture of learning from mistakes, incidents and complaints across the whole organisation (community as well as acute and between sites).

3.9 In November 2015 the Trust issued its first "Open and Honest" publication. This is available on the public website and has been promoted to staff internally. This approach to developing an honest and open culture will continue and be built upon with more promotion in 2016/17.

3.10 The Trust commenced a roll-out programme on lessons learnt in 2015/16. This will continue into 2016/17 and will place a significant emphasis on learning from SIs and the substantial body of valuable information within Datix reports. Achievements and lessons learned from the 2015/16 quality improvement programme will be provided in the final annual plan submission.

3.11 During the year the numbers of infection control outbreaks has necessitated a review of the causation factors including, a review of the Trust system processes and

procedures for minimising the risk of outbreaks and follow up investigation and management. The Trust is working with the TDA on a robust root cause analysis and infection review of these incidents. Any learning from these exercises will be taken forward in 2016/17.

3.12 Mortality

3.13 The Trust has recognised that it needs to strengthen its routine reporting and understanding of all mortality indicators. A reformed Mortality Review Group (MRG), chaired by the Medical Director was established during 2015/16; and a standard report format is being developed and will be in place by 2016/17.

3.14 The MRG is now routinely reviewing all deaths within the Trust to establish any potential adverse factors as well as retrospectively reviewing the mortality data. The aim is to continue to be transparent and clear on any individual service outliers even where the overall performance of the Trust is satisfactory. Divisional and local speciality mortality committees will continue. The Trust had no specific CQC alerts in 2015/16. Mortality data was also considered in the full CQC review during October 2015 (see 3.19 below).

3.15 In 2016/2017 the Trust will commence monitoring of misadventure and complication rates, alongside mortality indicators so that this information can be triangulated

3.16 National Publications

3.17 In 2015/16 the Trust reviewed relevant national publications including the Lampard and Morecombe Bay reports. A dedicated Board workshop considered the Morecombe Bay findings with the women and children division highlighted key issues and how the Trust compared and what action was or needed to be taken to address any remaining deficiencies.

3.18 In 2016/17 the Trust will continue to review and asses itself against any National Programs or standards that are published, and ensure that areas of non-compliance are actioned and monitored accordingly.

3.19 CQC

3.20 In 2015/16 the Trust had its first formal CQC assessment as a merged Trust. The formal report is still awaited from the CQC although the Trust did receive a letter in December 2015 with specific areas of concern. The Trust has set out its response to the issues identified in its letter of reply on 7th January 2016. The Trust will develop an overall action plan to address any areas of concern identified in the final CQC report.

3.21 Quality improvement plan

3.22 The Trust in 2015/16 has reviewed its quality improvement plan and continues the monitoring of the key indicators, reporting these in the monthly integrated performance report to the Board. Priorities in the Trust's quality improvement plan for 2016/17 have been developed and consulted on internally with key work stream operational and overarching leads, and at a strategic level with commissioners.

3.23 Quality-improvement is supported through the application of nationally recognised methodologies, such as lean, to maintain and sustain change.

3.24 Sign up to safety

3.25 The Organisation in 2015/16 signed up to the sign up to safety campaign and this will continue in 2016/17 and be embedded in the Trusts overall emphasis on safety and learning.

3.26 Staff well being

3.27 The Trust reviewed the feedback from staff surveys and has taken action to improve communication, develop its service strategy, provide feedback on issues raised, improve its appraisal processes and be clear about its staffing levels and processes for agreeing additional staffing. The Trust has also identified service areas where broader team-development would be beneficial and has made arrangements to facilitate this. The Trust will also be undertaking a broader organisational development programme in 2016/17 as described in section 4.19 below.

3.28 A key area of activity for the Trust during 2015/16 was to improve the compliance rates of staff with appraisals and mandatory training; with particular emphasis on those staff requiring safeguarding children and adults training. Compliance rates have significantly improved as a result and on-going monitoring and provision of courses will ensure this improvement is maintained.

3.29 Safer Staffing

3.30 The Trust has reviewed its nursing and midwifery workforce in 2015/16 using the safer nursing tool which has informed the review of nursing establishments, roles, functions and budgets. Daily acuity reviews of patients' needs are now in place which support the planning and rostering of staff to ensure patient safety is not compromised

3.31 In 2016/17 the Trust will continue to monitor itself against the National Quality Board's key objectives, including for allied health professionals and ensure this is linked with reporting to the Board.

3.32 Revalidation for medical and nursing staff

3.33 The Trust has recently purchased revised software to support medical revalidation that is also capable of supporting nursing revalidation. This system will be utilised to support the development of nursing revalidation in 2016/17.

3.34 Quality impact assessment

3.35 The co-ordinated oversight of the Trust's transformation agenda under a single programme structure has been revised to standardise the quality impact assessment (QIA) process for all service changes or cost improvement plans. The completion of QIAs is a gateway pre-requisite for all projects, prior to approval to proceed and includes the requirement for sign of by the Medical Director and Chief Nurse.

3.36 A structured QIA template is central to ensuring that the risk assessment process is a systematic and consistent with approaches used by many other Trusts. All proposed changes are evaluated against their likely impact on patient experience, patient safety, and clinical effectiveness. Appropriate clinical outcome measures are also identified for use in monitoring both the effectiveness of mitigation actions and the overall impact of the changes.

3.37 In-year monitoring of QIAs is integral to the delivery assurance of the annual plan and transformation programme and is overseen and triangulated on a monthly basis at a range of forums including: the Finance and Performance Committee of the Board, Integrated Governance Committee and Strategy and Transformation Committee.

3.38 Implementing seven day services

3.39 The Trust plan for seven day services reflects both pan-London quality standards and national seven day services clinical standards, delivery of which was overseen by the North West London 7-day working group during 2015/16.

3.40 Governance arrangements for the sector seven-day programme are being updated for 2016/17. To enable a shift from the programmes initial priorities around support, co-ordination and alignment, to a focus on the local delivery of standards.

3.41 Activities within the Trust will continue to be co-ordinated by the dedicated seven-day working project lead and clinical leads put in place at the end of 2015, who will:

- Develop and maintain the seven-day project plan
- Provide monthly progress updates to the Board, and
- Co-ordinate project work streams.

3.42 The Trust's 2016/17 plan applies a sequence of Plan-Do-Study-Act (PDSA) cycles utilising clinical audits to target three outcomes:

- Ensuring all emergency patients have a consultant review within 14 hours of admission
- Ensuring diagnostic interventions are completed within one hour for critical patients, 12 hours for emergency flow and 24 hours for inpatients, and
- Ensuring all patients on specialty wards have a daily consultant review 7/7.

3.43 The outcome of these audits will determine the priorities for developmental work. In addition the project lead and key clinicians are working with NHS England 7 day working leads on programmes targeting: consultant interventions, diagnostic services for 7 day working, and on-going consultant review.

3.44 PLACE Inspection

3.45 The Trust recognises that in 2015/16 the overall PLACE inspection was unsatisfactory and identified a range of areas that required improvement. Action has been taken in year to address these issues and the aim is to significantly improve the results in 2016/17. Mock inspections have commenced and improvements from these will continue to be embedded throughout the Trust.

3.46 The Chief Nurse will roll out a program of ward assessments in 2016/17 with a specific section on compliance PLACE standards of environment, care and service.

3.47 Ward and Service assessment

3.48 In 2016/17 there will be a quality and safety assessment process which will be led by the Chief Nurse. Each area will be assessed against the CQC standards with a clear scoring process and this will provide a focus for each area to improve. This methodical approach will support "ward to Board" visibility by being clear what is expected and the standards being achieved in each area.

3.49 Quality and safety data are routinely triangulated at least daily at "clinical huddles" lead by the Chief Nurse, with heads of nursing, matrons and ward managers. These review staffing and specialist input requirements in relation to clinical acuity and numbers of patients at risk of falls, pressure damage, cognitive impairment, safeguarding etc.

4 Workforce plan

[Note: where indicated [..] the workforce plan in final submission requires updating for planned budgeted WTE in April as the start point and agreed CIP schemes]

4.1 Baseline data for the workforce plan is derived from the electronic staff record for substantive staff and from the December 2015 financial report for temporary staff. The trajectories in the draft plan are derived from the financial plan and form the baselines on which divisions and corporate functions are completing detailed workforce plans that take full account of:

- Outputs of demand and capacity analysis
- Improvement, transformation and CIP plans
- Service developments and re-commissioning
- Corporate and clinical service support restructuring etc.

4.2 The current iteration of the workforce plan results in a reduction in total staffing of [143.3] whole time equivalents (WTE), or [1.5%] of the total workforce. This reduction is achieved primarily through non-medical non-clinical bank and agency reductions of [104.4] WTE and [33.4] WTE, respectively.

4.3 The clinical staffing numbers, in nursing and to a lesser extent for medical staff are profiled to take account of expected winter pressures from November 2016 onwards.

4.4 Workforce trajectories are expected to change in the final submission, as planning assumptions are clarified and as the pay-element of savings identified as part of the transformation programme team are clarified with managers and staff at challenge meetings taking place as part of the recovery planning.

4.5 The 2016/17 workforce plan will align with the cost improvement plan and will aim to reduce costs significantly in 2016/17 and provide more granularity will also be provided in setting trajectories for qualified nurses, healthcare assistants, doctors and allied health professionals.

4.6 Progressing post-merger integration

4.7 Three strands of activity will dominate 2016/17 activities aimed at progressing the alignment of the legacy organisations and realising merger benefits:

- Corporate function redesign
- Operational divisional management restructure, and
- Integration of acute and community services.

4.8 Workforce priorities

4.9 Workforce interventions in 2015/16 enabled the Trust to successfully reduce temporary staffing WTE by 18% and agency WTE by 41% over the 9 months to Dec 2015. However, both will remain significant challenges in 2016/17. As at December 2015 there were 1,250 WTE vacancies (13.5% of its 9,500 establishment) and a year-to-date average temporary staffing level of 1,500 WTE (or 16%).

4.10 The Trust acknowledges that 2016/17 will continue to be an unsettling time for staff, which will continue to drive increased turnover. Temporary staffing solutions may also be unavoidable as transitional arrangements whilst restructuring activities are completed. Nevertheless, the Trust will continue to pursue its aim of being agency free in 2016/17.

4.11 A range of restructuring activities will take place during 2016/17, building on changes commenced in 2015/16 to achieve closer integration of community and acute care pathways, improve patient experience and align corporate functions.

4.12 Priorities within the workforce strategy

4.13 The workforce strategy prepared as part of the merger recognised the instrumental role of staff – their skills, knowledge, behaviour and commitment – in enabling the Trust to provide an excellent patient experience and high quality of care. Over the medium term, the workforce strategy will also need to consider the implications of new roles and ways of working and the increasing proportion and number of patients of high acuity and dependency.

4.14 The workforce strategy remains a "live" document and will be refined in 2016/17 as the Trust clinical strategy is finalised. Implementation of the workforce plan is expected to continue to focus on the five thematic priorities established in 2015/16:

1. Becoming a model employer evidenced by improvements in national staff survey measures
2. Providing model careers, increasing the quality of leadership and investing significantly in the management capability of the organisation
3. Scoring highly in terms of staff engagement
4. Increasing workforce productivity by aligning individual contributions to service requirements, creating the ability to respond quickly and flexibly to changing service demands and ensuring that appraisal and objective setting is robust, and
5. Providing excellent HR support coupled with effective people management policies and practices.

4.15 Human Resources will continue to support service integration across sites and between acute and community, and the accompanying consultations. It will also support service reconfigurations resulting from the implementation of the SaHF program.

4.16 The corporate human resources function will have a new executive director from March 2016 and is expected to restructure to meet the requirements placed on it.

4.17 Additional priorities for 2016/17 include:

- Continuing to develop an effective partnership with staff side representatives
- Determining the impact of CIPs and improvement plans on workforce establishments
- Supporting divisions with staff development and the redesign of roles, especially in hard-to-recruit areas
- Developing leadership capacity and capability to deliver transformation
- Supporting the implementation of extended-day working
- Reviewing, harmonising or replacing legacy systems and processes, including harmonising the staff bank, and
- Implementing a dedicated sickness absence project to achieve a 15% reduction in sickness absence over 2016/17.

4.18 Many of the areas of improvement identified by Lord Carter's productivity review are already being addressed by the Trust. However, recommendations relating to workforce productivity will be revisited with a view to identifying further opportunities to address in 2016/17.

4.19 Organisational Development Programme

4.20 Significant organisational and workforce changes have already taken place and must be recognised. These have been as a result of the merger, clinical service reconfiguration driven by the SaHF programme and changes within the Trust itself. The reality of further significant changes, and on-going uncertainty as to what these might be, also needs to be recognised.

4.21 The Trust acknowledges that it urgently requires a comprehensive organisational development strategy and plan that address issues including:

- Supporting new clinical leaders and senior managers to deliver what is expected from their roles
- Effective communication of the organisation's clinical and service strategies
- Enabling staff to deliver change
- Developing organisational culture and identity, and
- Support and develop leaders for now and in the future.

4.22 This task will be a priority for the new HR director in 2016/17 and a limited provision is made in the financial plan to support this programme of work. Further requests for financial support will be sought from the TDA and commissioners once the full scope and scale of the organisational development programme's needs are clarified.

4.23 Recruitment and retention

4.24 The recruitment needs of the Trust must take account of both filling existing vacancies and replacing anticipated leavers. Analysis of turnover and vacancy rates indicates that it would require almost 1,200 new starters to fill current vacancies and offset natural wastage in 2016/17. Current vacancies within the Trust are being reviewed and may reduce following calibration.

4.25 The Trust will continue to use a variety of methods to recruit qualified and unqualified nurses and other staff. Dedicated work groups in place across the organisation are involved in pro-active recruitment of staff, particularly nurses. Local recruitment fairs and open days are well attended and have proved successful, particularly in recruiting qualified nurses; and good links exist with local universities. Ward managers will continue to be encouraged to run ward-based recruitment events in parallel with specialist campaign-led events.

4.26 Alternative and innovative approaches will continue to play a role in 2016/17, building on:

- "Virtual" recruitment fairs where candidates find out about employment opportunities through social media
- Using specialist headhunting agencies to target hard-to-recruit staff
- Offering all student nurses at the Trust a guarantee of a permanent appointment on successful completion of training, and
- "Growing our own", as was done by sponsoring cardiac technicians through degree programmes.

4.27 The Trust set itself the objective for 2015/16 of increasing the substantive clinical workforce (excluding doctors) by 252.8 WTE. Despite increasing the non-medical clinical workforce by 129 WTE in 2015/16 the number of nurses in the Trust decreased.

4.28 The focus on recruitment will aim to increase clinical workforce recruitment by a further 150 WTE in 2016/17 focussing primarily on increasing our nursing workforce. This is an ambitious target, over and above the requirement to meet staff turnover. The Trust will build on, and continue with, improvements put in place in 2015/16 that strengthened and streamlined recruitment and retention systems and processes.

4.29 A recruitment and retention strategy and detailed implementation plan were drawn up in 2015/16 with the primary aim of achieving a sustained decline in the reliance on temporary staff. The 2016/17 workforce plan aims to reduce temporary staffing usage by 140 WTE per month.

4.30 Recruitment and retention plans will continue to target the achievement of significant reductions in both vacancy rates and staff turnover. Notwithstanding that turnover in

London-based trusts is high on a national comparator due to the competitive nature of the labour market and other external factors.

4.31 The 2016/17 recruitment action plan will concentrate on:

- Improving and streamlining recruitment processes to reduce “time to recruit”
- Developing branded materials for use in recruitment
- Engaging with local academic institutions, including schools, colleges and universities
- Raising staff-awareness of the diverse range of financial and non-pay benefits available to them, including educational bursaries)
- Designing new roles and ways of working
- Diversifying employment options and flexibility
- Introducing new recruitment methods, and
- Using divisionally-focused recruitment plans to improve focus and targeting.

4.32 While nursing staff remain the most significant target-group for the recruitment plan, it is intended to apply across-the-board and to deal with shortages in all staff groups.

4.33 Staff retention

4.34 A clear commitment to staff training to develop a highly skilled and motivated workforce is central to the retention strategy. The Trust will continue to strengthen its status as the local employer of choice, supporting this with:

- Workforce policies such as for flexible working
- Provision on-site childcare at the NPH and EH site
- A well-established education, learning and development programme, and
- Staff-accommodation at the EH and NPH sites.

4.35 Postgraduate centres located at all three sites offer regular teaching programmes open to all staff. The establishment of an academic hub for health visitors benefited recruitment and retention of qualified and unqualified staff to a traditionally hard-to-recruit area. The Trust will seek to replicate this model in other specialist areas during 2016/17.

5 Financial plan

5.1 Financial planning approach

5.2 The Trust financial plan for 2016/17 is for a £61.5m deficit in line with the requirement of NHS Improvement. The plan derives from a starting point forecast 2015/16 deficit of £88.3m and takes into account the following:

- TDA planning guidance 2016/17
- National Tariff Consultation 2016/17[1]
- Commissioning intentions of CCGs and NHS England
- The Trust's financial recovery plan 2016/17
- Savings as a result of post-merger integration
- Impacts of the clinical strategy and associated service changes linked to the ongoing implementation of the Shaping a Healthier Future (SaHF) programme[2]
- Other supporting strategies including corporate, estates and IM&T, and
- The NHS Sustainability and Transformation Fund (STF) 2016/17.

5.3 The initial underlying recurrent financial position is estimated as follows:

- Non-recurrent income and expenditure included in the 2015/16 forecast is removed
- Recurrent impact of SaHF changes, e.g. the closure of the maternity unit on the Ealing hospital site and the opening of new wards on the Northwick Park site (NPH), is taken into account; as is the impact of service-decommissioning that occurred throughout the year (primarily affecting community services, such as Intermediate Care Ealing), and
- Annual transitional support received of £11m for the Central Middlesex Hospital site is removed as 2016/17 is the last year that this income will be received.

5.4 Table 4 sets out the contribution these adjustments make to the forecast £104.39m recurrent baseline deficit.

Table 4 2015/16 income and expenditure baseline

	NHS Patient Care Income	Other Income	Pay	Non pay	Total
	£m	£m	£m	£m	£m
2015/16 Forecast - M9	**566.52**	**98.09**	**(474.99)**	**(277.92)**	**(88.30)**
Non recurrent Benefits 2015/16	(10.58)	(16.63)	0.00	(4.14)	**(31.35)**
Non recurrent costs 2015/16	0.25	0.38	1.49	4.90	**7.02**
Recurrent pay savings (M12 run rate adjusted)	0.00	0.00	12.58	0.00	**12.58**
15/16 Service changes including 1516 decommissioning	(7.47)	(0.91)	5.18	0.41	**(2.80)**
Other - winter pressures/contract caps/ RTT	(4.66)	6.60	0.95	0.00	**2.89**
Recurrent 15/16 baseline I&E	**544.06**	**87.53**	**(454.80)**	**(276.75)**	**(99.96)**

5.5 Included in the 2016/17 plan is the Sustainability & Transformation General Fund of £21.5m for LNWHT.

5.6 The plan assumes a tariff inflator comprising 3.1% inflation, 2% efficiency and 0.7% CNST (on PbR prices) in 2016/17 in line with national guidance.

[1] To be confirmed by NHS England at the time of writing
[2] The North West London sector strategy for the reconfiguration of healthcare services

5.7 Table 5 sets out commissioning contract income assumptions. These have been estimated using the 2015/16 forecast, removing known non-recurring income, adding full year effects of SaHF and other in-year decommissioning and then applying assumptions around demand management (Quality Improvement Productivity and Prevention, QIPP) and growth.

Table 5 Contract income assumptions

Item	Value	Source	Note
Contract price inflation	+3.1% inflation -2% efficiency +0.7% CNST on PbR prices	National Tariff 2016/17	Average 1.5%tariff inflator. The inflationary increase includes an allowance to cover the cost pressure caused by changes to employer's NI contributions for staff in the NHS pension scheme and the CNST uplift.
CQUIN	Unchanged at 2.5%	National Tariff 2016/17	
Demand Management (QIPP) and growth	Thus the current plan assumes a zero net impact on growth and QIPP	QIPP and growth received from commissioners	QIPP schemes have been received from the main CCGs and NHS England. The Trust is in broad agreement with the majority of CCG schemes and the COO is currently undertaking final reasonableness checks. QIPP totals £19m and this has been included, with a corresponding cost reaction at 33%. Demographic growth assumptions have been agreed with CCGs. The Trust is modelling these against baseline income. Non-demographic growth is still under discussion. For this iteration of the plan growth is assumed to match QIPP at £19m, with a 33% cost reaction
Income Opportunities	£11m		This has been identified by an External review of income undertaken in the financial year, encompassing improved coding of activity. In addition contract negotiations will aim to minimise the imposition of local metrics.

5.8 In addition, the following changes to income streams have been factored into the plan:

- £21.5m STF funding
- Increase in the patient transport service contract value are treated as a pass through cost (£0.60m addition in 2016/17)
- Repatriation of ENT work from Imperial Healthcare NHS Trust (£1.1m)
- A net loss of £4.04m (comprising £14.86m income reduction offset by £10.82m cost reduction) as a result of service decommissioning and SaHF impact during 2016/17, including:
  - Adult services (£4.48m), STARRs (£3.29m) and community equipment services (£0.61m) for Harrow
  - Hammersmith and Fulham MSK (£2.01m)
  - Brent and Ealing wheelchair service (£1.19m)
  - Ealing maternity hubs (£0.14m)
  - Impact of the partial loss of Ealing cardiology service (£1.28m)

    - SaHF closure of paediatrics at Ealing Hospital planned for July 2016 (£1.86m)
- High-cost drug inflation (£0.86m)
- Lower education and training income as a result of reductions in the number of student doctors (£0.85m) and a decrease in the education tariff (£0.6m)
- numbers in 2016/17
- Research and development and other income-generation streams is estimated at forecast 2015/16 levels
- Funding received for CMH at £11m is added back onto the income baseline non-recurrently.

5.9 The expenditure plan uses the recurrent underlying position adjusted for the following cost pressures and reductions:

- 4.5% drug inflation (on non-excluded drugs) (£1.38m)
- Increase to employers NI (for staff in the pension scheme) estimated at £6m, and
- The NHS Litigation Authority has increased the Trust's clinical negligence premium (CNST) by £2.14m, although the closure Ealing Hospital's maternity unit is expected to result in a £2m reduction to the premium.

5.10 The National Tariff guidance indicates a pay inflator of 3.36% comprising a 1% pay award, 0.6% pay drift, -0.04% staff grade mix and 1.8% NI changes affecting pension scheme members. NHS Employers has also confirmed a 1% Agenda for Change pay award. A £1m provision for the new junior doctors' contract has also been made. In total, pay inflation is £13.7m or 3.1%.

5.11 The plan assumes service development costs associated with a new MRI scanner (£0.64m), with an accompanying income assumption of £0.57m. The full-year effect of the modular ward opened in January 2016 has also been included. Finally, the plan includes transformation costs of £2m. Any further cost-increases in costs would have to be covered by additional income of targeted support from the STF.

5.12 Capital Charges

5.13 The depreciation estimate has increased by £1.04m from 2015/16. It is calculated using the fixed assets on the balance sheet as at January 2016, plus an estimate of the fixed assets to be brought onto the balance sheet or to be disposed of in 2016/17. The public dividend capital (PDC) budget is estimated at 3.5% of planned average net relevant assets; a reduction of £1.88m is estimated. Loan interest is calculated at 3.5% of the outstanding balance. The Trust is expected to utilise the working capital facility from April 2016. In 2015/16 the Trust utilised the loan facility from July onwards as it had access to agreed PDC for the first quarter. As a result, this will increase interest charges by £0.73m.

5.14 Contingency

5.15 The financial plan contains a general contingency for £3.7m (0.5% of Trust expenditure), in addition to a £1m provision for CNST and £3.8m against improvement trajectory underperformance.

5.16 Capital

5.17 A five year capital plan is maintained to inform investment prioritisation consistent with the Trust strategy and to enable infrastructure developments to support transformation.

5.18 In line with NHS guidance, funding of the 2016/17 capital plan is primarily through internally-sourced depreciation of £13.3m, with the balance coming from interest-bearing capital investment loans (CIL). The TDA has confirmed a £4.7m CIL for a clinical portal IT project. A further £1.6m business case for additional beds is pending

approval. An additional £4.0m of IT-related projects were contained within the full business case for the merger, including an electronic document management system.

5.19 Clinical divisions, the estates directorates and Executive directors have worked together to reduce the level of over-commitment within the 2016/17 capital plan to £1.23m, just under 5% of available funds. The capital plan will remain under continuous review.

5.20 Risks

5.21 Risks to the delivery of the 2016/17 financial plan are summarised in Table 6, with mitigations.

Table 6 Implementation risks to the 2016/17 financial plan

Category	Risk	Mitigation
Commissioner Contracts	Plan assumes a level of QIPP and growth together with a cost reaction. Risk is that the activity changes do not materialise in line with current assumptions and cost reactions to changing levels of activity vary from the assumption.	Plan will be updated following progress on contract negotiations Close in-year monitoring of QIPP and demand with commissioners to flag early warnings where there is material over or underperformance
	Contract KPIs and penalties in excess of planned levels (2015/16 levels)	Reintroduction of the Income Maximisation Group with the objective of ensuring that contract penalties do not exceed 2015/16 levels. The plan assumes no National penalties subject to STF guidance and includes a contingency.
RTT	Risk of increased demand leading to RTT backlog growth in excess of the improvement trajectory, coupled with lack of capacity and requirement to reinstate waiting list initiatives.	Early warning linked to close monitoring of RTT performance and cost variances
Expenditure control	Control of cost base within planned level and failure to control the use of staff in excess of planned levels	Continuation of the transformation and improvement agenda to identify and monitor cost improvements and productivity and efficiency gains Weekly CIP meetings
Transformation and integration costs	Costs exceed planned levels (£2m)	Monitoring and forecasting of expenditure to ensure it stays within financial envelope Apply to STF for targeted funds
Decommissioning	The Trust is unable to remove all direct costs related to decommissioned services	Careful management of services decommissioned including any TUPE issues to ensure no residual costs remain
CIP	Failure to identify CIP and meet full CIP challenge	Co-ordinated support to divisions to identify CIP schemes and development of mitigations for gaps due to “unidentified schemes” and risk-adjusted values

Category	Risk	Mitigation
CIP – income maximisation	Ability to realise the £11m opportunity through better coding and capturing of activity (as identified in the 2015/16 review by Deloitte which found income to be below peer benchmarks in some specialities)	The Income Maximisation Group will aim to investigate and address areas to improve the capture of activity and increase income levels
Cash flow	Going concern impact of deficit plan	Interim rolling working capital facility agreed and available until March 2020, ensuring access to cash in the first half of the financial year 2016/17 subject to the repayment of current outstanding balance (on receipt of 2015/16 PDC funding)
SaHF	Stranded costs and income losses arising from closure of paediatrics at Ealing site	Close monitoring of the impact of closure by the Trust Application for SaHF transitional funding from TDA
	Above-plan increase in cost of modular beds at Northwick Park Hospital	Detailed modelling of pay and non-pay costs with Chief Nurse Close monitoring of expenditure against budget to highlight variances

5.22 Recovery programme

5.23 During the first half of 2015/16 the cost run-rate was forecast to exceed the planned deficit and immediate action was taken at that time to increase financial grip and control. Significant progress has been made to recover the in-year position.

5.24 An in-year recovery plan was developed and savings of £23.3m were required in order to meet the planned deficit. Temporary staffing controls and other tactical controls around non-pay expenditure have been implemented and are continuing to be closely monitored.

5.25 Since Month 5 the Trust has made significant progress in improving this position. In Month 7 the agency costs had reduced by 33% to £3.2m. Table 7 sets out other achievements made in year. Improvements are expected to continue through to the end of the financial year.

Table 7 2015/16 recovery plan achievements

Challenge	Progress made through recovery plan
£700k monthly spend on internal waiting list initiatives (WLIs)	Reduced to c.£50k by January 2016
£600k monthly on non-clinical agency/interims	Reduced the number of interims and will spend £2.2m less in the second half of the year
Only £3m of £6.8m planned corporate merger-savings had been removed from the run rate, with estates and ICT spending exceeding 2014/15	Corporate functions to save over £3m in the second half of 2015/16
Average monthly agency spend of £4.8m over April – August 2015 (12% of pay spend)	Agency spend reduced to £3.2m by month 7 (October), equating to 8% of pay spend

5.26 A financial recovery plan was submitted to the TDA in December 2015 identifying an improvement opportunity of £86m across the two years ending 31 March 2018. Draft divisional plans have been agreed in line with this plan and detailed plans are being developed in line with the annual planning table. Budget setting is due to be finalised by the end of February. Plans will be presented by budget holders to the Board at a Board away day in mid-March.

5.27 A governance structure is being established for delivery of all transformation work streams. Each work stream will have an Executive SRO and accountability mechanisms will support delivery alongside a co-ordinated central PMO.

5.28 The two-year financial recovery plan is focussed on seven key areas of work, which are cross-cutting across divisions:

1. **Clinical services "value for money"** (impact £21.0m – covers all nursing, medical, AHP and other staff groups involved in clinical service delivery)

   This will be achieved by various measures including: removal of WLI sessions; standardised better planning of leave; improved roster management; targeted reduction of agency usage; increased use of specialist nursing; reviews of medical staffing numbers and grades based upon detailed capacity and demand analysis, teaching and other requirements; roster changes; moving to team-based job plans; and reducing medical workforce costs by undertaking permanent recruitment.

2. **Clinical services productivity** (impact £7.7m – covers beds, wards, theatres and outpatient clinics)

   This will involve various work streams, including but not limited to: bed management reviews, productive/models ward methodology consistently applied, inpatient pathway reviews, full demand and capacity modelling across all clinical specialties, reductions in delayed discharges, increasing proportion of surgical time (lists running to time, all theatre lists being optimally booked, improved pre-operative assessments to reduce cancellations), rationalising staffing patterns to match demand, reviews of utilisation of outpatient services, reducing DNAs, and pathway-based reviews of outpatients and diagnostics.

3. **Back Office** (impact £20.0m – covers management and corporate teams, clinical administration and divisional management)

   This will be achieved by: rationalisation of structures, skill mix, reducing layers, increasing span of control, strengthened accountability, consistency, right-first-time; and the use of technology to aid efficiency.

4. **Non Pay Cost Control/Avoidance** (impact £8.0m)

   To be achieved through procurement and materials management, blood products and medicines management.

5. **Estates and Facilities** (impact £6.0m)

   To be achieved through site and service reconfiguration; site utilisation, service efficiency and cost reduction; energy efficiencies and unit cost improvements; and income improvement.

6. **Income and Coding Completeness** (impact £22.0m)

   To be achieved through appropriate coding of clinical income, negotiation of more favourable contract terms, full PbR contracts, accurate activity capture and improved performance against targets that attract fines and penalties.

5.29 A further £1.3m contribution arises from a variety of “bottom-up” divisional initiatives and projects that are being worked up as part of weekly divisional challenge and budget setting meetings.

5.30 Given the scale of the financial recovery plan, it is recognised that whilst the Lord Carter review provides a useful guide as to the extent of the efficiency and productivity improvement potential, the Trust requires a wider transformation across the breath of its services and back office and support functions. Lord Carter’s findings will form an important part of the programme structure for delivery of productivity-based projects and will be referred to as an important benchmark against which progress will be measured internally within the organisation.

5.31 Agency spend

5.32 The Trust will extend its declared “agency free” ambition through 2016/17, building on good progress already made in strengthening the understanding of workforce needs through establishment reviews and clinical skill-mix adjustment.

5.33 Robust mechanisms to challenge daily staffing utilisation to avoid agency usage will continue, with added focus on divisional cost-reduction commitments and the corporate requirement to adhere to the NHS Improvement capped rates unless patient safety issues emerge. Approval for agency usage will continue to rest with senior managers, with the additional control of a nominated executive director accountable for temporary staffing decisions.

5.34 All non-framework nursing agency use will be eliminated as the rationalisation of commercial contracts and relationships with agency suppliers is completed.

5.35 The Trust’s temporary staffing action plan (which is informed by the NHS Improvement diagnostic tool) will be kept under review and updated as necessary. A dedicated, fully integrated and co-located internal temporary staffing team will be put in place at the end of Q1. Temporary staffing processes will be harmonised around the roll-out of an integrated cloud-based e-Rostering system at the start of Q1, offering opportunities to:

- Enable a step-change increase in bank worker recruitment as an agency avoidance and quality improvement measure
- Provide additional functionality such as improved visibility of available bank shifts and simplified online booking requests
- Automatically generate temporary and permanent staff utilisation information both retrospectively and prospectively, to enhance reporting at corporate and local levels, identify best practice and encourage this to be shared; and as a basis for critical challenge, and
- Allow intervention where controls need strengthening.

5.36 Nursing agency expenditure has been set a 2016/17 ceiling of no more than 10% of the overall pay bill, with the intention of extending this to all occupational groups.

5.37 Corporate agency expenditure reduction is a priority of the financial recovery plan, with the ambition to terminate all arrangements put in place during 2015/16 by the end of Q1. In 2016/17 interim use will be restricted to time-limited or specialist activities requiring skills that are unavailable internally or that cannot be covered without detriment to business as usual. Management or administrative interim utilisation will remain subject to authorisation and close monitoring at executive director level.

5.38 Vacancy-reduction remains a significant driver of long-term sustainable decreases in bank and agency usage. This objective remains challenging in light of the vacancies and competition for health-worker recruitment across London.

5.39 Sickness-rates, which are a second major driver of bank and agency usage, will continue to be the focus of a dedicated sickness and absence project targeting all staff groups.

5.40 Procurement

5.41 The cleansing of spend data during 2015/16 coupled with NHS eClass categorisation provides the basis for a comprehensive and systematic review all non-pay spend. 2016/17 will be the first year of a robust three-year procurement strategy, linked to a £6m savings plan. The Trust's primary goal is to increase competition through a combination of:

- Technology, in particular sourcing tools and e-auctions
- Adoption of framework contracts and mini-competitions, and
- Collaboration with local and national clusters.

5.42 A contract register will be put in place to ensure legal compliance and reduce risk by enabling timely renewal notifications of major contracts. Existing controls will be strengthened by a combination of communicating standing financial instructions and business rules and "hard-wiring" these into the eCommerce system to increase compliance.

5.43 Standardisation groups, supported by a clinical procurement specialist, will be used to provide clinical safety assurance and to facilitate clinical engagement in the procurement transformation agenda.

5.44 Capital planning

5.45 The Trust has planned for capital expenditure to be funded by c£14.0m of internally generated funds (i.e. depreciation), £1.6m PDC for the modular beds business case and £3.3m for the clinical portal ICT project. This funding was part of the 2015/16 ITFF application and is subject to confirmation.

5.46 As part of the merger business case, a further £4.0m was identified for merger-related ICT projects. This source of this funding, whether as PDC or loan, will be confirmed at either outline business case (OBC) or full business case stages of these projects. There is currently one project, for the implementation of an electronic data management system that is earmarked for this funding.

5.47 The Trust is progressing three business cases (relating to the Ealing, NPH and CMH sites) in support of SaHF. Each business case will require funding to reach full OBC compliance. However, as the urgent and critical nature of works required at NPH cannot be addressed on the decision-making timescale of the SaHF programme. The Trust is discussing the need to expedite the NPH business case with the TDA and SaHF programme. The current financial plan excludes the estimated £11m cost of developing the NPH business case.[3] This potential funding requirement is highlighted in the event that it is not available through SaHF.

5.48 A 5 year capital plan will be formulated to identify the Trusts capital investment priorities to support the delivery of its service, transformation and estates strategy over the period. This will be collated through a number of sources, including:

- Submissions of capital requirements from Clinical and Corporate divisions, including service development requirements
- Rolling equipment replacement programme, from finance fixed asset register and a detailed analysis provided by the Trust's EBME service provider, and
- Input from the Directorate of Strategy to ensure capital plans are in line with the strategic direction of the organisation.

[3] Estimated as 10% of expected capital build costs

5.49 The 5 year Capital plan will inform the development of an annual plan that will enable the Trust to prioritise investment of its available capital funds and prioritise business cases for seeking further external funding support.

5.50 Estates and facilities optimisation

5.51 Estates and facilities opportunities are a significant component of the financial recovery plan (see 5.28) and their implementation will be overseen as part of the transformation programme. The need to align changes to the SaHF process means that the realisation of some major estates benefits is dependent on the SaHF timeline and future delays to the SaHF programme. Subject to this caveat, the principle objectives for 2016/17 are:

- To leverage the potential of changes taking place across the Trust, in particular those under the remit of the transformation programme, to leverage improvements in estate utilisation and as opportunities rationalise estate[4]
- The re-procurement of soft facilities management, and
- Maximising the usage of the existing facilities, allowing where possible for tenanted space to be reduced and identifying redundant assets for sale.

5.52 The NPH and Ealing Hospital sites were constructed almost 50 years ago and have antiquated plant and machinery; this is particularly the case at Northwick Park. Works to improve the high voltage supply to NPH will be completed in 2016/17 improving site-resilience. Works to other systems such as heating and ventilation will continue as funding is available to replace inefficient and time-expired plant.

[4] The CMH, Ealing hospital and community sites have the greatest identified potential for estate rationalisation

6 North West London Sustainability and Transformation Plan

6.1 Agreement was reached at the end of January 2016 that the eight boroughs in North West London (NWL) would develop jointly a five-year Sustainability and Transformation Plan (STP) combining local place-based health and wellbeing plans, with NWL-wide strategies and collaborative plans.[5] The NWL STP's geographical footprint is the largest in London (Figure 1).

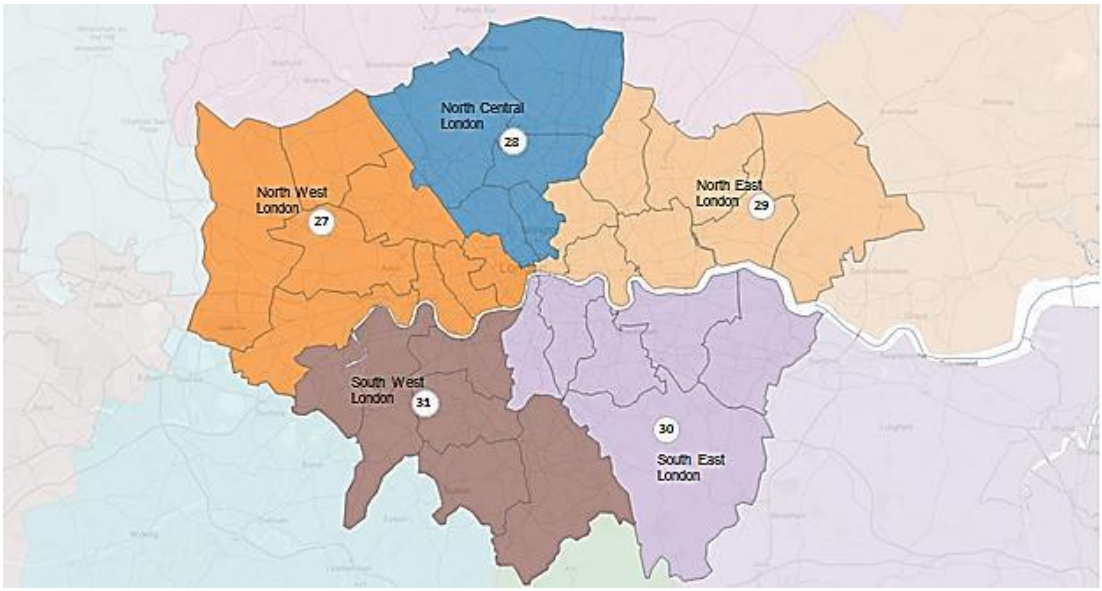

Figure 1 London region footprints map (Gateway reference 04902)

6.2 An STP "charter" setting out objectives, ways of working, governance and timelines has been created and each of the constituent CCGs is in the process of assessing local priorities to address the three challenges in the Five Year Forward View (FYFV). It is anticipated that much of this work will be overseen by Health and Wellbeing Boards.

6.3 A NWL Strategic Planning Group (SPG) has been in place since 10th March and local borough-based STP planning groups are engaged in drafting emerging priorities and highlighting differences across NWL. A draft STP submission will be available for Board review at the end of April.

6.4 The North West London vision for the health and care system

6.5 The STP is expected to be shaped by the sector's vision for Whole System Integrated Care and by the implementation of SaHF for acute care services.[6] Whose aims include:

- Empowering individuals to direct their own care and support
- Co-ordinating care and delivering it in the most appropriate setting
- Integrating systems so that funding flows to where it is needed
- Improving clinical outcomes and the experiences for patients, carers and staff
- Increasing integration across primary and secondary care, and
- Making services financially sustainable.

6.6 A key response of commissioners to the FYFV is the stated ambition to form an Accountable Care Partnership by 2018/19 (Table 8), which will include appropriate service contributions from local authorities, mental health and voluntary sector. The

[5] NHS North West London Collaborative of Clinical Commissioning Groups are a collaboration of NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith & Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG, and NHS West London CCG.
[6] http://integration.healthiernorthwestlondon.nhs.uk/

aim is for all eight CCGs in North West London to work within a single financial control total with the NHS service providers.

Table 8 Responding to NHS FYFV 2016/17 Planning Guidance (January 2016)

2016/17	2017/18	2018/19
New ways of working (new care models, development of new teams and cultures) New governance structures (shadow ACP boards, joint commissioning governance) Clear approach to roll out and system assurance Outcomes agreed, baselines set, approach to shared incentives agreed Shared informatics functions rolled out Monitor new models of care against shadow population-level capitated budgets Continue to embed co-production pathways of working Sharing learning and best practice across and beyond NWL	Roll out to full coverage Legal entities formed Capitated budgets and risk share agreed Multi–year contracts developed	WSIC operating in full end state
Implications for LNWHT		
Depends on areas of priority Changes linked to SaHF reconfiguration are in plan: paediatric service closure at Ealing hospital Paediatric and maternity reconfiguration are in Trust plans Impact on the development and approval of: • the OBC for critical operational services on the NPH site • the SaHF business cases for NPH, CMH and Ealing local hospital	Larger scale service contracts implies service procurement will have greater potential impact (positive or negative) Dependent on agreed service model for Ealing local hospital and Central Middlesex Hospital Ealing hospital local A&E/UCC model	

6.7 The implementation of SaHF service reconfigurations and the continuing drive, through QIPP and procurement initiatives, to rebalance healthcare spending out of hospital settings are expected to be the main impacts of the STP priorities on the Trust in 2016/17.

6.8 In 2017/18 and beyond the Trust's operating plan will be increasingly influenced by:

- Care networks in which service delivery involves partnerships in which the Trust is not the lead provider
- Priorities dictated by transformation funding allocations, which in turn will involve collective bids by the sector linked to national programmes (e.g. Vanguards)
- Whether the Trust is successful in securing multi-year contracts

- Increasing expectations of new, collaborative approaches to service transformation and the sharing of operational and financial risk, and
- Implementation of the Trust business cases in response to critical operational needs and SaHF.

29 March 2016