London North West Healthcare NHS
NHS Trust

2016-2017 Annual Plan

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1 Background

1.1 Who we are

1.2 London North West Healthcare NHS Trust is one of the largest integrated care Trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow. The Trust was established on 1 October 2014 through the merger of The North West London Hospitals NHS Trust and Ealing Hospital NHS Trust.

1.3 Our Trust looks after:

- Central Middlesex Hospital
- Community services across Brent, Ealing and Harrow, including Clayponds Rehabilitation Hospital in south Ealing, Meadow House Hospice in Ealing, the Denham Unit at CMH and Willesden Centre for Health and Care in Brent
- Ealing Hospital
- Northwick Park Hospital
- St Mark's Hospital

1.4 We care for the a diverse population of nearly 900,000 people living in Brent, Ealing and Harrow, as well as patients from all over the country and internationally at St Mark's, our specialist hospital for colorectal diseases.

1.5 The Trust employs some 11,500 people, including over 1,300 doctors and 4,000 nurses, as well as therapists, scientists, other health professionals, and administrative and support staff; making it one of the largest local employers.

1.6 Research and development and undergraduate and postgraduate education and training play a vital role in the Trust.

1.7 The Trust annual plan and five year Northwest London Sustainability and Transformation Plan

1.8 All NHS organisations have to prepare an operational plan for the year ahead, from 1 April 2016 to 31 March 2017. The plan describes the range of healthcare activities we will provide over the next 12 months, how we intend to fund this work and our plans to ensure we have the staff needed to provide care. We explain how we intend to meet National standards for providing

Figure 1 Our core services

- Full emergency department services at Northwick Park and Ealing Hospitals, both supported by urgent care centres
- Emergency assessment and treatment services including critical care. The Trust is a designated trauma and stroke unit
- Acute and elective surgery and medical treatments such as day and inpatient surgery and endoscopy, outpatients, services for older people, acute stroke care and cancer services
- Comprehensive maternity services including consultant-led care, midwifery-led natural birth centre, community midwifery support, antenatal care, postnatal care and home births. There is also a special care baby unit
- Children's services including emergency assessment, inpatient, outpatient and a range of universal community services
- A variety of community services for adults including district nursing and the community bedded facilities
- Specialist community services supporting older people and those with long-term conditions and disability such as diabetes, podiatry and musculoskeletal services
- Diagnostic services including pathology and imaging services
- A wide range of therapy services including physiotherapy and occupational therapy
- Education, training and research

access to services and what we will do to improve quality, safety and the efficiency of what we do.

1.9 Our plans for the coming year are part of a bigger five-year plan we are creating with local GPs, social services and other partners. The aim of this Sustainability and Transformation Plan is to improve the health and wellbeing of people across northwest London and make services more joined-up.

1.10 Over the coming year – our second year since merging – we want to take major steps towards creating a single organisation. To help us on our way we have planned to complete three important exercises to plan for the future:

- We will decide on our clinical priorities for the future
- We will launch an organisational development programme to help us become an excellent integrated care organisation, and
- We will work with staff, partners and service users to agree the vision, values and behaviours that will guide us.

1.11 At the heart of the plan is a commitment to keep improving quality and to make sure services are easy to access. We will work with the Shaping a Healthier Future (SaHF) programme that is coordinating investments and changes in healthcare services aimed improving the quality of our estate and moving services closer to peoples' homes.

1.12 Achieving our vision and values

1.13 To evolve as an organisation we must create an identity and culture to support the ambitions we have for our hospital and community services. Six key objectives will drive this work and help the Trust to achieve its vision "**to provide excellent clinical care in the right setting by being compassionate, responsive and innovative**".

1.14 Our objectives are as follows:

1. Improving our focus on quality and safety
2. Improving patient experience, satisfaction and engagement
3. Creating a sustainable workforce that is well-led and engaged in the improvement of services
4. Ensuring financial stability
5. Planning for our future, and
6. Continuing the journey to becoming an excellent integrated care organisation.

1.15 These objectives lie at the core of plans for each of our services and are linked to what each staff-member is being asked to do.

1.16 We are committed to working with partners across northwest London (NWL) to meet the future needs of this part of one of the most vibrant, multicultural and historic capital cities in the world. The emerging Sustainability and Transformation Plan discussed in section 6 is an opportunity to collaborate with other organisations. To transform prevention, integration and digitisation, and address the big challenges for people in NWL.

1.17 Divisional priorities

1.18 The annual plan is underpinned by detailed plans for each operating division that were presented to the day Board at a full-day workshop on 14th March. These plans are shaped by the Trust's overarching priorities:

- To address quality and safety issues highlighted by the Care Quality Commission (CQC) [at the time of writing 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 integrate the clinical leadership and operational management of our hospital and community based services and realign our clinical divisions to provide a more seamless service.

1.19 Note on the draft final plan

1.20 Contract negotiations for 2016/17 have yet to be concluded following the receipt of formal contract offers from the Trust's main Clinical Commissioning Groups (CCGs) initially on 11th March (although there have been subsequent changes to these offers including the full withdrawal of the Ealing CCG offer due to affordability issues). The Trust has continued to engage pro-actively with all its commissioners and significant progress has been made towards agreeing activity volumes and financial assumptions but they are not finalised. Brent and Harrow contracts are close to finalisation. Ealing CCG contract is still some way off as latest offer only came in on Friday 15th April and there are outstanding issues on the specialised commissioning contract from NHSE.

1.21 Version 6 of the annual plan as presented is based on the planned £61.5m deficit budget for 2016/17 (after IFRIC and other NHS accounting adjustments the unadjusted deficit is £62.9m) in line with the NHS TDA Control Total and assumes a £21.5m Sustainability and Transformation Fund allocation. Budgets for 2016/17 are being finalised on this basis.

1.22 Finance, activity and workforce plans included in the 18th 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 Plans for 2016/17 are based on the best estimate we can make of the likely demand that there will be for hospital-based services. The starting point for calculating what this will be is the number of patients seen last year. We then consider the impact that various factors, such as growth due to changes in our population and changes in behaviour, seasonal effects, service developments etc. to arrive at a best estimate summarised in As can be seen we are expecting the need for all major hospital-centred services to grow. In some areas the growth will be significant due to a combination of population growth, changing demographics and determinants of health, and taking into account the need to meet national waiting time standards.

2.2 Table 1 overleaf.

2.3 As can be seen we are expecting the need for all major hospital-centred services to grow. In some areas the growth will be significant due to a combination of population growth, changing demographics and determinants of

health, and taking into account the need to meet national waiting time standards.

Table 1 Amount of work our hospitals are planning for compared to last year

	2016/17	Previous Year	Change
GP and other referrals	223,000	215,000	3.7% increase
Admissions for planned care	70,400	69,600	1.1% increase
Emergency admissions	73,700	70,300	4.8% increase
A&E attendances	304,000	303,000	0.4% increase
Diagnostic tests[1]	197,000	191,000	3.2% increase
Outpatient attendances,[2] of which	634,000	588,000	7.8% increase
New/first outpatient attendances	195,000	184,000	5.8% increase

2.4 The estimated demand for services at each site is used in turn to estimate the number of clinical staff, clinics, operating theatres, diagnostics and other resources across all specialties to make sure these are sufficient to support the delivery of planned safe care. This includes detailed analysis, using tools provided by the NHS Intensive Support Team, to ensure we take account of waiting lists for elective care and critical diagnostic tests, for example in endoscopy and radiology.

2.5 This work continues to be refined as we work with our commissioners to understand the impact of changes that they are planning to make, in particular as part of Quality Improvement Productivity and Prevention (QIPP) plans. The aim is to make sure 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 Delivering national targets

2.7 National access standards, in particular around the priorities to be seen within four hours of attending A&E, maximum waiting times of 18 weeks from referral to treatment for planned care (RTT), the time to treatment for urgent cancer referrals and waits for key diagnostic tests, were monitored closely throughout 2015/16. This will continue.

2.8 Commissioners supported the Trust throughout 2015/16 by targeted investments of system resilience monies in areas where demand significantly exceeded funded capacity. Making the following possible:

- 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 patients' recovery goals outside of an acute setting, and
- Outsourced diagnostic endoscopy activity to reduce waiting times.

[1] Excluding endoscopies
[2] Excluding clinics that are not consultant-led

2.9 Goals for improving our performance against these key national standards in 2016/17 are summarised in Table 2. Joint work to finalise and agree these goals with local CCGs is still on-going as at 18th April 2016. The ambitions set out below will rely on support from CCGs and planning by the Systems Resilience Group (SRG).

2.10 A major achievement in the past year was a step-change improvement in A&E four hour waiting times following considerable and sustained efforts by front line staff. This was made possible by the opening of new modular wards at Northwick Park Hospital (NPH) in January 2016.

Table 2 2016/17 Provisional improvement trajectories (18th April 2016)

Access Standard	National Standard	Trust Baseline April 2016 (est.)	Improvement Trajectory
A&E four hour waiting time	95%	88.5%	Progress towards 90.5% by March 2017 (recognising bed closures for fire compliance)
Referral to Treatment (RTT) incomplete pathways	92%	89.0%	92% from July 2016
62 Day cancer waiting times	85%	66.7%	Achieve and maintain 85% from August 16
Over 6 week diagnostic waiting times	99%	97.3%	99% from July 2016

2.11 In terms of planning for the additional pressures over the winter period, we are working with our commissioning partners on the basis that demand for hospital services will be at least at 2015/16 levels. Key to the Trust's response to peaks in demand for emergency services are the 48 new general and acute beds created at NPH in January 2016, 12 medical beds at Ealing Hospital (EH), 20 step-down beds at Central Middlesex Hospital (CMH) and 5 community rehabilitation beds at Clayponds in Ealing.

2.12 Additional safeguards are provided through the SRG, which will co-ordinate commissioners' response to unplanned changes in demand.

2.13 Table 3 and Table 4 list various improvements to care pathways and service developments that are still being discussed with our commissioners.

Table 3 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.

Pathway	Objective
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 4 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		

2.14 Expanding critical care capacity (Table 4, reference 1) is the most important development being proposed for 2016/17. A recent independent review confirmed that there is sufficient demand to justify increasing dedicated critical care bed capacity in the Trust. Changes have already been made acting on recommendations from the CQC and further improvements are planned as we work on the approval of a major capital case to increase the number of critical care beds in the Trust.

2.15 We aim to continue innovating. Next year's plans include:

- Providing virtual, online and telemedicine clinics (including a pilot study on Skype radiology clinics) and GP advice lines, meaning fewer hospital visits for patients
- Making specialist services available in northwest London for which patients and their families and carers currently have to make a long journey for diagnosis and treatment (such as sacral nerve stimulation)
- Introducing treatments and technologies that have not previously been available, such as laser ablation and endoscopic resection, making day case treatment an option where overnight stays were required before, and
- Expanding our capacity to manufacture supplies to allow patients who need parenteral feeding to receive this in the community.

3 Quality plan

3.1 Quality priorities are set out in detail in the Trust's quality improvement plan for 2016/17. Particular aspects of quality we will concentrate on over the next year include:

- Building on the improvements made over the past year to make sure we respond even more quickly and effectively to complaints
- Strengthening processes, guidance and training around the reporting, investigation and learning from serious incidents, including fortnightly executive reviews
- Promoting an honest and open culture
- Addressing findings of the recent review of systems, processes and procedures for minimising the risk of infection control outbreaks
- Strengthening routine reporting and scrutiny of mortality indicators at specialty, divisional and Trust levels, to identify and address any potential adverse factors
- Continuing to take an active part in national campaigns like "sign up to safety", and
- Acting on the findings of independent assessments, such as patient-led assessments of the care environment (PLACE).

3.2 The Chief Nurse, as the executive lead for the quality plan, will oversee its delivery together with a dedicated Board committee for quality and risk. The central governance and risk teams will be redesigned in 2016/17 to ensure that clinical services get the most effective support in quality improvement. For example to help front line staff apply nationally recognised methodologies, such as lean, to maintaining and sustaining change. The central team will work alongside dedicated clinical governance and audit leads appointed in 2015/16 to each division.

3.3 The Trust will continue to review and asses itself against any National Programs or standards that are published over the course of the year, including the findings of the CQC assessment at the end of 2015 that are still to be received. In each case the Trust will develop an action plan to address and mitigate areas of concern.

3.4 Potentially negative implications of the transformation agenda, service changes or cost improvement projects for quality are assessed through a standardised quality impact assessment (QIA) process. No change can proceed without assurance from the Medical Director and Chief Nurse that impacts on patient

experience, patient safety and clinical effectiveness are understood and can be mitigated adequately. Quality impact is part of the monthly monitoring of annual plan progress.

3.5 Methodical self-assessment will be a central to quality and safety management in 2016/17. Each clinical area will be assessed against CQC standards and other independent frameworks, such as those used for PLACE, to provide "ward to Board" visibility of what needs to improve and set standards the Trust expects to be achieved.

3.6 Safe and effective staffing

3.7 We have acted on feedback from staff surveys by taking steps to improve communication, improve appraisal processes and be clearer about processes for agreeing additional staffing. Arrangements have already been taken to facilitate team-development in services where a need for this has been identified. This type of support will continue under the broader organisational development programme taking place in 2016/17 (see 4.10).

3.8 During 2016/17 we will continue our drive to improve compliance with appraisals and mandatory training requirements, particularly for those staff requiring safeguarding children and adults training.

3.9 The detailed review of our nursing and midwifery workforce completed in 2015/16 has informed the setting of nursing staffing levels, roles, functions and budgets for 2016/17. Day-to-day planning will continue through "clinical huddles" led by the Chief Nurse, with heads of nursing, matrons and ward managers. At which staffing and specialist input requirements will be considered against the number and acuity of patients and a range of other quality and safety data. Similarly detailed scrutiny of allied health professionals will also take place. Staffing will also be reported routinely to the Board.

3.10 Software purchased in 2015/16 to support medical revalidation will also be used to support nursing revalidation in 2016/17.

3.11 Implementing seven day services

3.12 The Trust plan for seven day services is aligned with plans across London and co-ordinated with partner organisations across northwest London. This work will continue to be supported by a dedicated seven-day project team and clinical leads that will focus on three key priorities:

- Ensuring consultant review of all emergency patients 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.

4 Workforce plan

4.1 To predict the Trust's staffing requirements for the coming year we took account of:

- Demand for services
- The impact of improvements in efficiency and other changes
- Services that commissioners have awarded to other organisations, and

- The restructuring of Trust functions following the merger.

4.2 We expect the workforce to reduce by 328 whole time equivalents (WTE), or 3.6% (see Table 5), mainly due to:

- Losing our Harrow community services contract to another provider[3]
- The closure of inpatient paediatric services at Ealing Hospital as part of the SaHF programme, and
- Post-merger consolidation of corporate functions.

Table 5 Headlines from the Trust workforce plan showing the changes expected over the next year

	2016/17	Previous Year	Change
Monthly staff turnover	1.1%	1.3%	
Sickness absence rate	3.0%	3.4%	
Vacancy rate	11.1%	13.2%	

Total staff, of which	**8,848**	**9,176**	**328 fewer**
Medical staff			
Substantive*	1,167	1,147	20 more
Bank†	68	69	
Agency‡	66	65	
	1,301	**1,281**	**20 more**
Nursing staff			
Substantive	2,702	2,795	92 fewer
Bank	435	383	52 more
Agency	132	158	26 fewer
	3,269	**3,336**	**67 fewer**
Other clinical staff groups (therapists, scientific and technical roles)			
Substantive	1,108	1,152	44 fewer
Bank	57	67	10 fewer
Agency	45	48	3 fewer
	1,210	**1,267**	**57 fewer**
Non-clinical staff			
Substantive	505	600	95 fewer
Bank	168	206	38 fewer
Agency	9	10	1 fewer
	682	**816**	**134 fewer**

* Substantive staff on full or part-time contracts

†Staff registered on the Trust's bank are available on a temporary basis and are paid on an hourly basis for time worked.

‡Temporary staff are provided through third party "agencies" at rates that are subject to a national cap of 55% above the cost of the equivalent substantive role.

[3] This is the main cause of the reduction in substantive nursing and other clinical staff in 2016/17.

4.3 Workforce priorities

4.4 In 2016/17 we aim to take advantage of the opportunity the merger has provided to simplify corporate functions and the management of our operational divisions and to integrate acute and community services. We will build on last year's successes in reducing temporary staffing. Redesigning services and creating new types of roles to help reduce the number of long-term vacancies and pursue our aim of being agency free in 2016/17.

4.5 In common with NHS organisations across London, we expect recruitment to remain challenging – particularly of registered nurses. Our ambition to increase the proportion of substantive staff has to be achieved against a background of an annual staff turnover of 1,150 WTE, a very competitive labour market and staff uncertainty due to the restructuring activities taking place.

4.6 Staff skills, knowledge, behaviour and commitment are instrumental in enabling the Trust to provide an excellent patient experience and high quality of care. The workforce strategy will be refined in 2016/17 as the Trust clinical strategy is finalised. As this work progresses the Trust will continue with the priorities set in 2015/16:

1. Becoming a model employer
2. Providing model careers and investing in leadership and management capability
3. Scoring highly in terms of staff engagement
4. Making our workforce more productive, responsive and flexible to changing service demands, and
5. Providing excellent HR support.

4.7 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
- Implementing a dedicated sickness absence project to achieve a 15% reduction in sickness absence over 2016/17, and
- Looking again at the recommendations from Lord Carter's review for further opportunities to improve workforce productivity.[4]

4.8 Progress against these priorities will be monitored monthly by the Board and the Staff and Patient Committee to ensure that risks and concerns are identified promptly and mitigated, and that actions are taken to address issues that arise throughout the year.

[4] Operational productivity and performance in English NHS acute hospitals (www.gov.uk)

4.9 Our medium-term ambition to foster greater autonomy for divisional clinical services will be supported by corporate functions through better tools and information in crucial areas, coupled with training. Examples include the introduction of a new service line reporting system in Q2, which will provide detailed information to support decision-making. Changes made to the business case process will also take effect, to better align divisional plans and Trust investment priorities.

4.10 Organisational development

4.11 Significant organisational and workforce changes have already taken place since the merger and must be recognised. To which are added the ongoing clinical service changes due to SaHF and those led by the Trust itself. A provision has been made in the financial plan to support the Director of Human Resources in creating a new organisational development strategy and plan:

- To support clinical leaders and senior managers in their roles
- To communicate the organisation's strategy effectively
- To enable staff to deliver change, and
- To Develop organisational culture and identity

4.12 We will seek further financial support from NHS Improvement and commissioners once the scope and scale of organisational development needs are clarified.

4.13 Recruitment and retention

4.14 The Trust will continue to use a variety of methods to recruit qualified and unqualified nurses, doctors and other clinical and non-clinical staff. We have set ourselves the ambitious aim to Increase our substantive clinical workforce by 150 WTE in 2016/17.

4.15 Dedicated groups are involved actively in recruitment, particularly amongst nurses. Local recruitment fairs and open days have proved successful, particularly in recruiting qualified nurses; and good links exist with local universities. We will continue to encourage ward-based recruitment events in parallel with specialist events and campaigns. Other innovations planned for 2016/17 include:

- "Virtual" recruitment using social media to reach out to potential candidates
- Using specialist agencies to target hard-to-recruit staff
- Offering all student nurses guaranteed permanent appointments, and
- "Growing our own".

4.16 The Trust will build on plans put in place last year:

- To improve and streamline recruitment and reduce the "time to recruit"
- To engage with local academic institutions
- To design new roles and ways of working, and
- To use targeted recruitment.

4.17 Our retention strategy relies on building our reputation as the local employer of choice. Through offering valued benefits such as flexible working, on-site childcare and staff accommodation, and a well-established education, learning and development programme open to all staff. We intend to create more

academic hubs in 2016/17 to help attract staff into hard-to-recruit specialist areas, using the successful academic hub for health visitors as a model.

5 Financial plan

5.1 Financial planning approach

5.2 The Trust plan for 2016/17 is forecast to result in a £61.5m for the year (the forecast deficit for 2015/16 is £88.3m). This was arrived at by:

- Adjusting for income and expenditure that applied only in 2015/16, including grants and penalties, and changes to services in that year
- Taking account of the full effect of savings made part-way through 2015/16
- Applying National prices for 2016/17 (which are 1.5% higher than in 2015/16 overall)
- Projecting contract income assumptions based on commissioning plans, including other in-year decommissioning and effects of SaHF
- Factoring in the impact of the Trust's savings plan, service changes and any associated investments to enable these improvements, and
- Adding £21.5m financial support that the Trust expects to receive from the NHS Sustainability and Transformation Fund (STF).

Table 6 Summary financial plan for 2016/17

	NHS Patient Care Income	Other Income	Pay	Non pay	Total
	£m	£m	£m	£m	£m
2015/16 Forecast	**566.5**	**98.1**	**(475.0)**	**(277.9)**	**(88.3)**
2015/16 adjustments	(22.5)	(10.5)	20.3	1.2	(11.7)
Underlying 1516 financial position	**544.1**	**87.5**	**(454.8)**	**(276.7)**	**(100.0)**
2016/17 adjustments	8.7	0.3	0.0	0.0	9.0
Service changes 2016/17	(13.6)	(0.1)	8.3	1.7	(3.7)
Service developments / investments	0.6	0.0	(0.2)	(0.4)	(0.1)
Pay and price inflation	0.0	0.0	(13.7)	(4.7)	(18.4)
Other	0.0	11.6	0.0	(3.5)	8.0
Depreciation, PDC and financing charges	0.0	0.0	0.0	(0.2)	(0.2)
Transformation Costs	0.0	0.0	0.0	(2.0)	(2.0)
Contingency	(3.8)	(1.0)	(2.3)	(1.4)	(8.5)
1617 CIP	11.0	0.0	13.5	8.4	32.9
2016/17 Financial Plan pre STF	**546.8**	**98.2**	**(449.2)**	**(278.9)**	**(83.0)**
STF Allocation		21.5			21.5
2016/17 Financial Plan	**546.8**	**119.7**	**(449.2)**	**(278.9)**	**(61.5)**

5.3 Two critical assumptions made in relation to next year's commissioning income are:

- The impact of planned Quality Improvement Productivity and Prevention (QIPP) schemes to reduce demand for hospital services by £19m is assumed to be wholly offset by additional activity arising from demographic growth, and
- Based on the findings of an external review the Trust has estimated that £11m income will come from more accurate recording of activity that was previously not correctly paid for.

5.4 Other significant changes to income and expenditure in 2016/17 include:

- Repatriation of ENT work from Imperial Healthcare NHS Trust[5]
- Lower education and training income as a result of reductions in the number of student doctors, a reduction in transitional funding and a decrease in the education tariff
- Funding for CMH at £11m.
- 4.5% drug inflation (on non-excluded drugs)
- Increase to employers NI (for staff in the pension scheme) estimated at £6m, and
- A £2.14m increase in the Trust's clinical negligence premium. A £1m contingency is held against this assumption, although the closure of Ealing Hospital's maternity unit should reduce the premium by £2m.

5.5 Pay costs are expected to change by 3.36%, the main elements of which are a 1% pay award and 1.8% due to National Insurance changes. A £1m provision has been made for the impact of the new junior doctors' contract.

5.6 The plan assumes service development costs associated with a new MRI scanner, an expansion in the cardiac catheterisation laboratory at NPH and the transfer of some elective activity from Imperial Healthcare NHS Trust.

5.7 Finally, the plan includes transformation costs of £2.5m and a contingency of 1%. Any further cost-increases would have to be covered by additional income or targeted support from the STF.

5.8 Capital plan

5.9 The Trust will review the priorities on its five year capital plan regularly to ensure they are consistent with the Trust strategy, to enable essential infrastructure developments to support its transformation and a rolling equipment replacement programme.

5.10 The 2016/17 capital plan will be primarily internally-funded through depreciation of £13.3m, with the balance coming from interest-bearing capital investment loans (CIL). A £4.7m CIL has been confirmed for a clinical portal IT project and a further £1.6m business case for additional beds is awaiting approval.

[5] Pre-existing arrangements under which Imperial Healthcare NHS Trust delivered ENT clinics at EH under a service level agreement with the Trust have been replaced, at Ealing CCGs request, with the Trust providing this service; reducing the need for patients to travel to receive treatment.

5.11 The merger business case identified a further £4.0m for merger-related IT projects. This source funding for these projects will be confirmed at either outline business case (OBC) or full business case stages. One project currently earmarked for this funding is the implementation of an electronic document management system.

5.12 The Trust is progressing separate business cases for EH, NPH and CMH in support of SaHF. Each will require funding to reach OBC compliance. Due to the urgent and critical nature of works required at NPH the Trust is discussing pursuing this case outside of SaHF with NHS Improvement and SaHF. The estimated £11m costs of this option are not included in the financial plan.[6]

5.13 Risks

5.14 Risks to the delivery of the 2016/17 financial plan are summarised in Table 7, with mitigations.

Table 7 Implementation risks to the 2016/17 financial plan

Category	Risk	Mitigation
Commissioner Contracts	QIPP plans will not succeed resulting in the Trust experiencing higher than planned activity	Close Joint monitoring with commissioners to give early warnings
	Commissioners impose more aggressive financial penalties	Dedicated internal monitoring group
RTT	Excess demand drives up waiting lists, with insufficient planned capacity to address carry out the additional work	Early warning linked to close monitoring
Expenditure control	Failure to control costs, especially pay costs	Transformation programme, coupled with weekly monitoring of CIP performance
Transformation and integration costs	Transformation programme costs exceed plan (£2m)	Monitoring and forecasting of expenditure. Application to STF for additional financial support
Decommissioning	The Trust is unable to remove all direct costs related to decommissioned services	Careful management of decommissioned services, including TUPE issues, to minimise residual costs
CIP – delivery expenditure	Failure to identify CIP opportunities	Support through transformation programme

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

Category	Risk	Mitigation
CIP – income maximisation	Ability to realise the £11m opportunity through better coding and capturing of activity[7]	Dedicated work stream under the Income Maximisation Group
Cash flow	Going concern impact of deficit plan	Interim rolling working capital facility agreed and available until March 2020
SaHF	Stranded costs and income losses arising from closure of paediatrics at EH	Close monitoring and SaHF-led application to NHS Improvement for transitional support
	Above-plan increase in cost of modular beds at NPH	Detailed planning of pay and non-pay costs coupled with close monitoring
STF	Failure to meet agreed performance trajectories results in withholding of STF allocation	Close monitoring and management of performance to provide early warning of issues that may impact on meeting trajectories

5.15 Recovery programme

5.16 A recovery plan was developed and put into action during 2015/16 to increase financial grip and control. Savings of £23.3m were achieved allowing the Trust to meet its plan through temporary staffing controls and other tactical controls around non-pay expenditure. Improvements coming out of the recovery plan include:

- Reducing monthly waiting list initiative spend from £700k to less than £50k
- Reducing non-clinical agency expenditure by £2.2m in the second half of 2015/16, from £600m a month pre-recovery
- Reducing average monthly agency spend from £4.8m to £3.2m

5.17 A two-year financial recovery plan over the period to 31st March 2018 was submitted to the TDA in December 2015 identifying cross-organisational opportunities, including:

1. **"Value for money" from clinical services** – work streams with an aggregate impact of £21.0m from measures involving clinical staff, including: removal of waiting list initiatives; better leave-planning; improved roster management; increased use of specialist nursing; reviews of medical staffing and grades based upon detailed capacity and demand analysis etc.
2. **Clinical services productivity** – work streams with an aggregate impact of £7.7m from measures including but not limited to: better bed management; applying "productive" models; reviewing inpatient pathways; demand and capacity modelling across all clinical specialties; reducing delayed

[7] Identified in the 2015/16 review conducted by Deloitte that found income below peer benchmarks in some specialities

discharges; increasing theatre efficiency; rationalising staffing to match demand; optimizing the utilisation of outpatient services and diagnostics etc.

3. **Back Office** – work streams with an aggregate impact £20.0m from measures targeting corporate teams, clinical administration, and corporate and divisional management: rationalising of structures and skill mix; reducing layers; increasing span of control; strengthened accountability, consistency; "getting it right-first-time"; using technology to aid efficiency etc.
4. **Non Pay Cost Control/Avoidance** – work streams with an aggregate impact of £8.0m achieved through better procurement and materials management (including blood products and medicines)
5. **Estates and Facilities** – work streams with an aggregate impact of £6.0m achieved through: site and service reconfiguration; better site utilisation; cost reduction through procuring Trust wide services, e.g. in soft facilities management; energy efficiencies and unit cost improvements; improving income from tenanted space; identifying redundant assets for sale etc.[8]
6. **Income and Coding Completeness** – work streams with an aggregate impact of £22.0m achieved through: appropriate coding of clinical income; negotiation of more favourable contract terms; accurate activity capture; improved performance against targets to reduce penalties etc.
7. **"Bottom-up" divisional initiatives** – providing a further £1.3m contribution from projects being worked up as part of weekly divisional challenge meetings.

5.18 Divisional and whole-Trust plans have now been agreed in line with this two-year plan as part of the annual planning process and incorporated into budgets for 2016/17.

5.19 In view of the scale of the change agenda and financial recovery plan, dedicated governance arrangements are now in place to oversee the delivery of the transformation programme through work streams each of which has an Executive SRO. Board accountability and assurance are co-ordinated through a central PMO.

5.20 External best practice will be used to identify and challenge the extent of efficiency and productivity improvement across the Trust's wide-reaching transformation programme. For example, Lord Carter's findings noted in 4.7 will inform the programme structure around productivity-based projects as well as providing benchmarks against which progress is measured.

5.21 Agency spend

5.22 The Trust will extend its declared "agency free" ambition through 2016/17. Routine mechanisms are in place to challenge staffing utilisation and avoid agency usage. These will continue, with the added commitment to adhere to the NHS Improvement capped rates and the Trust's all-staff agency ceiling of £32.610m. All non-framework nursing agency use will be eliminated and the

[8] Some major estates benefits are dependent on the SaHF timeline. Realising these is subject to the caveat arising from future delays to the SaHF programme.

rationalisation of commercial contracts and relationships with agency suppliers completed.

5.23 Over the first quarter of 2016/17 we will put in place a dedicated, fully integrated and co-located internal temporary staffing team; harmonise temporary staffing processes harmonised; and roll out an integrated cloud-based e-Rostering system. Allowing a step-change in the way in which we manage temporary staffing.

5.24 Corporate agency expenditure reduction is a priority, with the ambition to terminate all arrangements put in place during 2015/16 by the end of Q1. After which interim use will be restricted to specialist activities requiring skills that the Trust does not have. Sickness absence, the other major driver of temporary staff usage, will be the focus of a dedicated project targeting all staff groups.

5.25 Procurement

5.26 2016/17 is the first year of a new three-year procurement strategy during which we aim to use a combination of technological solutions, frameworks and collaboration to increase competition to drive down costs. A contract register will be put in place to ensure legal compliance and reduce risk, with a communication campaign aimed at strengthening controls and compliance. Standardisation groups will be used to provide clinical safety assurance.

5.27 Estates and facilities optimisation

5.28 The NPH and Ealing Hospital sites were constructed almost 50 years ago and have antiquated plant and machinery; this is particularly the case at NPH. 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.

6 North West London Sustainability and Transformation Plan

6.1 Emerging priorities in the STP

6.2 Agreement was reached at the end of January 2016 that the eight boroughs in NWL would develop jointly a five-year STP combining local place-based health and wellbeing plans, with NWL-wide strategies and collaborative plans.[9] Previously, NWL CCGs have stated their ambition to form an Accountable Care Partnership (ACP) by 2018/19.

6.3 The NWL STP's geographical footprint contains proportionately the largest population in London (Figure 2).

[9] NHS North West London Collaborative of Clinical Commissioning Groups is a collaboration of NHS Brent CCG, NHS Central London CCG, NHS Ealing CG, NHS Hammersmith & Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG, and NHS West London CCG.

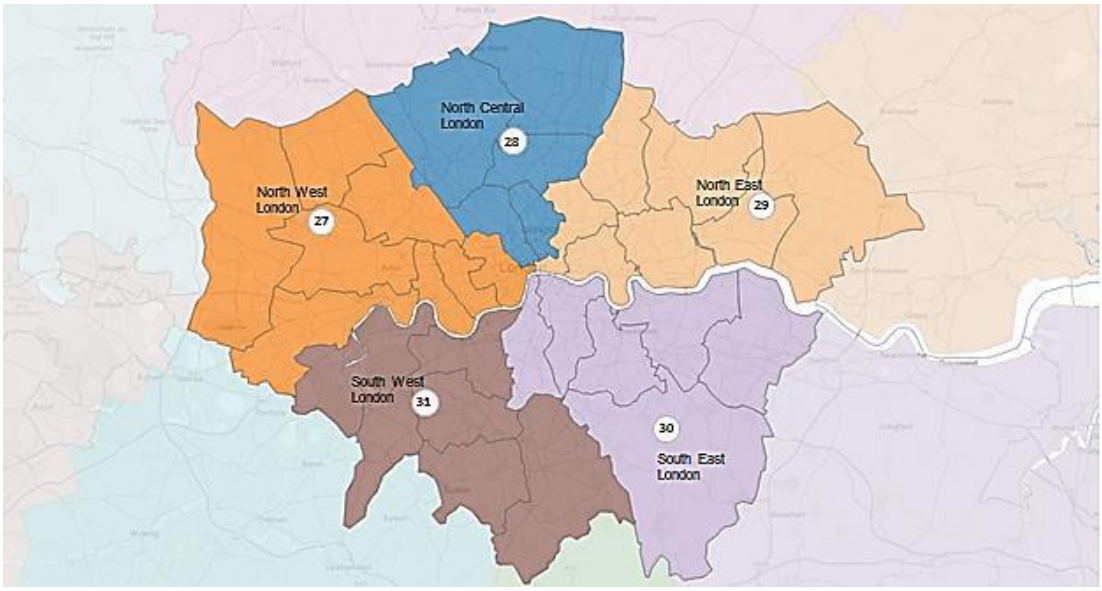

Figure 2 London region footprints map (Gateway reference 04902)

6.4 An STP "charter" setting out objectives, ways of working, governance and timelines has been created. The NWL Strategic Planning Group (SPG) has been in place since 10th March to oversee the development and implementation of the plan.

6.5 Since January, local borough-based STP planning groups have brought together representatives from providers, commissioners, social services, local authority public health teams and patient groups to assess local priorities and the three challenges in the Five Year Forward View (FYFV).

6.6 Local and overarching priorities arrived at through this process formed the basis for the draft STP: "*Our plan for North West Londoners to be well and live well"*, that was submitted on 15th April. Key elements of which include:

- Recognition of complex health needs, variation between health outcomes linked to wealth, unemployment, and the substantial deficit in health and social care finances; as the main challenges facing NWL as a whole
- An intention to focus effort on the following population-segments: mostly healthy; one or more long-term conditions (LTCs); cancer; severe and enduring mental illness; learning disability; severe physical disability; and advanced dementia / Alzheimer's
- Building on SaHF, i.e. the shift of activity into the community from hospital settings and the reconfiguration of acute services
- Recognising critical success factors including principles for the system as a whole, as well as responsibilities for residents and system leaders
- Proposed governance arrangements under a NWL Health and Wellbeing Board and Strategic Planning Group, with a tri-partite decision-making structure comprising the CCG governing bodies, local authority Cabinets and a Provider Board (Chaired by the Chief Executive of Imperial Healthcare NHS Trust and on which the Trust sits)
- Measures to support staff engagement, workforce development and organisational development, and
- Common improvement priorities summarised (see Table 8 below).

Table 8 Common improvement priorities in the draft STP (15th April version)

Health and wellbeing	Care and quality
• Support people to stay mentally and physically well • Reduce social isolation, and • Improve children's mental and physical health and well-being.	• Ensure access to the right care at the right time • Reduce variation in outcomes linked to severe and enduring mental illness • Improve the quality of care for people in the last phase of life • Reduce variations linked the day of the week on which services are accessed • Reduce unwarranted variations in the management of LTC • Reduce health inequalities and disparities in outcomes for cancer, heart disease and respiratory illness

6.7 STP Themes

6.8 Three broad themes have emerged during the preparation of the draft STP: prevention, integration, and technology and innovation. Notably, the integration theme encapsulates both the closer integration of services across providers and a vision of delivery by joint teams. At the time of writing the emerging delivery priorities that are most likely to be of relevance to future Trust plans are:

- The ongoing commitment of commissioners to demand management and market-shaping strategies across NWL
- Greater pooling of health and care funding
- Pan-NWL workforce planning
- Moves towards capitated payments for health and social care services, and
- Sharing data and intelligence, reducing reliance on paper and digital empowerment of the public.

6.9 Adaptations to the Trust plan may be required as the implications of these ambitions becomes clearer. In 2017/18 and beyond it is anticipated that the Trust's operating plan will be influenced increasingly 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

6.10 Implementation of the Trust business cases in response to critical operational needs and SaHF.

6.11 Risks to the STP

6.12 The most significant risks whose mitigation will need to be addressed are:

- Opposition to hospital reconfiguration
- Workforce and skills shortages
- The ability to achieve behaviour change
- Poor quality and unsuitable estate
- The funding gap
- Demand growth, and
- Barriers to information sharing.

6.13 Notably, many of these apply equally to the Trust's annual plan. In common with these, several will required national support as part of their mitigation, for example access to capital.

7 Abbreviations

A&E	Accident and Emergency
ACP	Accountable Care Partnership
CCG	Clinical Commissioning Group
CIL	capital investment loan
CIP	Cost Improvement Programme
CMH	Central Middlesex Hospital
CNST	Clinical Negligence Scheme for Trusts
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission (CQC)
EH	Ealing Hospital
FYFV	NHS England Five Year Forward View (published in October 2014)
HENWL	Health Education Northwest London
IFRIC	International Financial Reporting Standards Interpretations Committee
KPI	key performance indicator
LNWHT	London North West Healthcare NHS Trust
LTC	long term conditions
M12	Month 12 of the financial year beginning on 1st April, i.e. the month of March
MRG	Mortality Review Group
NI	national insurance
NPH	Northwick Park Hospital
NWL	Northwest London
OBC	outline business case
PbR	payment by results
PDC	public dividend capital
PDSA	Plan-Do-Study-Act improvement cycle
PLACE	Patient-led Assessments of the Care Environment
QIA	quality impact assessment
QIPP	Quality Improvement Productivity and Prevention
RTT	referral to treatment
SaHF	Shaping a Healthier Future
SI	serious incidents
SPG	Strategic Planning Group
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Plan
WLI	waiting list initiative
WTE	whole time equivalent

09 May 2016