Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
30 November 2016
11.30 – 13.00
W12, Hammersmith Hospital

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Chairman	11.30	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 28 Sept 2016	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 28 Sept & 23 Nov 2016	Chairman		2
1.5	Action Log and matters arising	Chairman		3
2	**Operational items**			
2.1	Patient story	Director of nursing	11.35	4
2.2	Chief Executive's report	Chief executive		5
2.3	Integrated performance report	Safe/effective: Medical director Caring: Director of nursing Well-led: Director of P&OD Responsive: DD Medicine & Int care DD surgery, cancer & CV DD Women's, chil'n & CS		6
2.4	Month 7 2016/17 Finance report	Chief finance officer		7
3	**Items for decision or approval**			
3.1	Appointment of external auditors	Chief finance officer	12.10	8
3.2	Trust strategy document	Chief executive		9
4	**Items for discussion**			
4.1	CQC update report	Director of nursing	12.25	10
4.2	Sustainability and transformation plan	Chief executive		11
4.3	Agency reporting to NHS Improvement	Director of P&OD		12
5	**Items for information**			
5.1	NHS Improvement Q2 performance report	Chief executive	12.45	13
6	**Board committee reports**			
6.1	Finance and investment committee (23 Nov)	Committee chair	12.50	14
6.2	Redevelopment committee (23 Nov)	Committee chair		15
6.3	Quality committee (16 Nov)	Committee chair		16
6.4	Audit, risk & governance committee (12 Oct)	Committee chair		17
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
			12.55	
9	**Date of next meeting**			
	Public Trust board: Wednesday 25 January 2017, New Boardroom, Charing Cross Hospital			

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 28 September 2016
11.30 – 13.00
Clarence Wing Boardroom, St Mary's Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerry Acher	Deputy chairman
Dr Rodney Eastwood	Non-executive director
Peter Goldsbrough	Non-executive director
Dr Andreas Raffel	Non-executive director
Sarika Patel	Non-executive director
Victoria Russell	Designate non-executive director
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
Dr Julian Redhead	Medical Director
In attendance:	
Jan Aps	Trust company secretary (minutes)
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Prof Tim Orchard	Divisional director, medicine & integrated care
Prof TG Teoh	Divisional director, women's, children's & clinical support
Prof Jamil Mayet	Divisional director, surgery, cancer & cardiovascular
Michelle Dixon	Director or communications
Guy Young	Deputy director, patient experience
Stephanie Harrison-White	Head of patient experience

1	**Administrative Matters**	**Action**
1.1	**Chairman's opening remarks and apologies** The Chairman welcomed members and the public to the meeting, noting apologies from Nick Ross and Prof Gavin Screaton. He extended a particular welcome to those attendees who had recently been appointed to board positions.	
1.2	**Board members' declarations of interests** There were no declarations of interest made at the meeting.	
1.3	**Minutes of the meeting held on 27 July 2016** The minutes were accepted as an accurate record of the meeting.	
1.4	**Record of items discussed at Part II of board meeting held on 27 July 2016** The Trust board noted the report.	
1.5	**Action Log and matters arising** The Trust board noted the update from David Wells regarding bank and agency spend.	
2	**Operational items**	
2.1	**Patient Story** Prof Sigsworth introduced the Patient Story, reminding the Trust board that at the January meeting members had expressed concern that there was sufficient resource to support patients with learning difficulties (only one post at that time). The Trust had	

	committed to increasing understanding and awareness of how to support such patients; this had been reported to the Trust board in May. The story outlined in the paper sought to demonstrate continued improvement and provide assurance. AM, the respite care home manager, where WH resided spoke of the particularly positive experience that WH had as he returned on many occasions for treatment – she highlighted the care, respect and compassion that was demonstrated by the staff at all levels and in all areas. AM had been visiting the hospital sites for many years, and was delighted to see the great improvement in the way her clients were being treated. Both the Chairman and Dr Batten extended appreciation and thanks to AM and WH. Responding to a query from Sir Gerry Acher, Prof Sigsworth noted that awareness of the needs of patients with learning disabilities was encompassed in the safeguarding training undertaken by all clinical staff. The Trust board welcomed the patient story and took assurance in the improved service being provided to patients with learning disabilities.	
2.2	**Chief Executive's report** Noting that most issues were the subject of specific papers, Dr Batten highlighted the following: • The junior doctors' contract would be the subject of a high court decision that day; the Trust continued to work in a collaborative way with the junior doctors, and was pleased to note that all industrial action had been suspended. • The bio-medical research centre (BRC) had been awarded £90m over the next 5 years; whilst this was a reduction in funding, it was still the highest funding awarded to a single AHSC. Noting the increase in funding to the UCLP BRC, Sir Richard Sykes commented that they had a greater number of research clinicians engaged in fundamental research. • Chelsea & Westminster NHS FT were to share the Trust's electronic patient record platform, which would be a great opportunity for improving care across the two trusts. Kevin Jarrold, the Trust's chief information officer (CIO) would become the joint CIO of both trusts, enabling great efficiency, effectiveness and co-ordination, particularly in the implementation of the global digital excellence programme. The appointment was a reflection of the strong working relationship developing across the two organisations. • Responding to a query from Dr Andreas Raffel, Prof Sigsworth confirmed that the timing of the lift upgrade programme needed to balance availability of capital funding and the level of disturbance acceptable to patients, either due to frequency of breakdown or due to the extended refurbishment period. The Trust board noted the chief executive's report.	
2.3	**Integrated performance report** SAFE/ EFFECTIVE: In commenting on the safety and effectiveness indicators, Dr Julian Redhead particularly noted that: standardised mortality rates remained comparatively low; reporting of serious incidents was slowly increasing whilst severe harm remained very low (reflecting a good reporting culture); MRSA cases remained at zero, but cases of C difficile had risen above the trajectory (each case was being reviewed carefully to identify, and reduce future risk of, lapses of care or incorrect antibiotic procedures). The Chairman commented that to eradicate MRSA, given the age of the infrastructure, was a particular achievement. Responding to a query from Peter Goldsbrough, Dr Redhead outlined the work that had been undertaken during 2016 to embed learning from incidents, to use Datix to provide feedback to those who reported incidents, and also outlined a range of initiatives in place as part of embedding a safety culture. Peter Goldsbrough asked which of the indicators were considered to be prospective rather than retrospective, and queried whether scores in these were lower. Dr Redhead reflected that the aim was for continuous improvement in all areas.	

	CARING: Prof Sigsworth noted that introduction of app technology had helped in achieving an increase in the FFT outpatient response rate, but that satisfaction was reported as having decreased; whilst disappointing, the additional feedback was considered useful in identifying where further improvement could be achieved. The technology was being considered for introduction in the emergency department where response rates remained low. Patient and family feedback remained positive in relation to the change in approach being taken with complaints, and they continued to be responded to in a timely fashion. WELL-LED: David Wells reported that as part of the issues being addressed in the occupational health department, timeliness of recruitment clearances had reduced, but additional resources were returning this to a more acceptable position. Responding to Sarika Patel, he acknowledged that core mandatory training for junior doctors remained low; this was being addressed by electronic training results between trusts, and also Dr Redhead noted that there were potentially more doctors trained for whom the results had not yet been entered. A far more positive position was expected for the next board report. Mr Wells was pleased to report that sickness rates continue to fall. He also noted that voluntary turnover remained stable (though noting that the vacancy rate was increasing), appraisal rates were good, and bank usage appeared to be replacing use of agency (agency use remained higher in areas of particular skill shortage). Responding to Dr Eastwood's positive comments on the GMC report, Dr Redhead was pleased to note the improved comparative position. In response to a query from Sir Gerry Acher, Prof Sigsworth confirmed that internal promotion continued strongly, providing good opportunities for staff wishing to progress; staff were also being 'rotated' between sites to provide new opportunities for staff, and apprentice opportunities were being explored. RESPONSIVE: Prof Orchard commented that the emergency department reflected equally on the flow through the hospital as on the activity within the department; a trajectory had been agreed, which had been mainly met since April, but would not be achieved in September. Increasing attendances, particularly at Charing Cross Hospital, with significant growth in ambulance attendances suggested a change in conveyancing; this would be discussed further with London Ambulance Service. Prof Orchard outlined the programme of actions and redevelopment in training to reduce the pressure on all areas, and considered the Trust would finish the financial year with a 'run-rate' at 95%, but recognised the vulnerability of the performance to a bad winter. Prof Orchard reported that he was now writing to Vocare on a weekly basis, and was meeting with the chief executive and chairman of the CCG to discuss the shortcoming in the service provided by Vocare. This included that, rather than remove 26,000 attendances in the emergency department, attendances were actually rising, and particular issues in the streaming of patients, and late presentation of patient to the emergency department (resulting in breaches – a two per cent impact on performance). There had been no further clinical incidents leading to potential clinical harm. Prof Mayet reported that six of the eight cancer targets had been met; the Trust underperformed against the 62-day screening target, and 62-day GP referral to first treatment standard (as a result of late referrals from other hospitals – more appropriate monitoring methodology would result in the Trust achieving this target in 2017/18). There continued to be a number of elective cancellations, mainly caused by the pressure of additional non-elective patients in the system. Prof Teoh reported that the diagnostic targets had been met in August, and that outpatient 'did not arrive' patients had reduced slightly at 11.8% - the target was 10%. The outpatient improvement programme was improving the experience of patients using these services. The Trust board noted the report.	
2.4	**Month 5 2016/17 Finance report** Richard Alexander presented the month 5 financial report confirming that both the	

	Trust in-month and year-to-date positions remained slightly ahead of plan. Activity had been above plan, and was reflected in an income position £7.4m above plan year to date. Pay was favourable to plan, with agency costs continuing below those of the previous year and also below the agency cap. Non-pay was adverse to plan, although this was partly off-set by favourable variance in income. The focus continued in relation to the CIP programme and productivity improvement working with PwC. The Trust board noted the report.	
2.5	**Referral to treatment (RTT) performance update and recovery plan** Prof Mayet outlined the elective care pathways, via the two week wait (for suspected cancer) and the 18 week pathway (for other diagnoses). The target was for 92% of patients to be treated within 18 weeks of being referred by their GP; the Trust was achieving 83% and was expected to worsen until the data validation exercise was completed (end December 2016). Investigation had identified that the inappropriate data entry in the patient administration system introduced two years previously was the main cause, alongside the inherent complexity of the RTT rules. Audit had identified six specialties where there were issues and these were being carefully audited (by end December 2016) to identify patients requiring treatment and to ensure that no patients had suffered harm as a result of extended waits. The focus would be to move to ensure accurate data entry (right first time), and a programme of re-education was in place to achieve this. Whilst as much activity as possible would be undertaken within the Trust, some elective procedures would be undertaken by private providers. The Trust board noted the report.	
3	**Items for decision or approval**	
3.1	**NWL sustainability & transformation plan** Dr Batten introduced the report, noting that the plan sought, for the first time, to describe the strategic direction agreed by partners across a geographic footprint (44 across England) to develop high quality, sustainable health and care services in line with the Five Year Forward View. The local footprint covered the eight boroughs of NW London, a total spend of £4 billion across health and care. The plan contained some early population analysis. The focus was on redesigning services such that people remained as well as possible at home or in the community and did not require hospital-based services. Along with clinical plans there were also work-streams focusing on workforce, ICT and estates. The governance surrounding the plan and organisational structure required further attention, but at present there was a Transformation Board (of which Dr Batten was a member) chaired by a CCG Chair, which would develop recommendations for the individual accountable bodies to support (there was no delegation of authority to the groups beyond that held by the individual attendees). It was acknowledged that there was significant work to be undertaken on stakeholder and public engagement; the Trust had started on this. Responding to a query from Sir Gerry Acher, Dr Batten confirmed that the Trust was not signing up that the strategies outlined would deliver the size of the gap identified; there was more work to be done on the financials and how /if the actions outlined could and would address the gap. Moving from an illness service towards a health service required upfront funding; the centrally held Sustainability and Transformation Fund sought to provide a level of funding, but the health bodies' requirement to develop two year business plans would work in parallel with this. There was also a central desire to move towards a system wide control total, which would require a completely new approach. Fundamentally, the three principles (health and well-being; care and quality; finance and efficiency) were the right direction, but it would not be an easy transition. Dr Batten noted that, within the Trust, she was supported in this work by a wide range of others, including: Dr Redhead (specialist commissioning), Prof Orchard (accountable care partnerships); Kevin Jarrold (ICT); David Wells (workforce) and Anne Mottram (strategy). The Trust board approved, in principle, the NW London Sustainability and	

	Transformation Plan, and delegated authority to the chief executive to approve the final version for submission subject to the nature of the proposed amendments.	
4	**Items for discussion**	
4.1	**CQC update report including OPD inspection preparedness** Prof Sigsworth presented the report, focusing on the Trust's preparation for the CQC inspection in late November 2016, outlining both the comprehensive outpatient improvement programme, and self-assessment undertaken as part of the preparation (resulting in two 'good' and two 'requires improvement' scores). Sarika Patel commented that, as noted earlier in the meeting, the FFT scores for outpatients were rather low. Prof Sigsworth acknowledged this, and reflected that the feedback highlighted that the main concern was delays in the clinics themselves; she considered that greater engagement would be the way to address this. She recognised that the CQC 'responsive' domain was the most vulnerable indicator. The Trust board noted the report.	
4.2	**National cancer patient experience results** Prof Sigsworth introduced the paper which demonstrated, after a number of years of poor results, a much improved position suggesting that the approach being taken to improve the experience of patients with cancer, notably the Trust /Macmillan partnership, had been successful. She particularly noted the dedication and consistently high standards delivered by the clinical nurse specialists and Dr Katie Urch. The Trust board was pleased to note the improvement demonstrated in the report, and supported the Trust's continuing approach to improving the experience of patients with cancer.	
4.3	**Emergency planning, resilience & response (EPRR) – bi-annual update** Prof Sigsworth presented the EPRR report, which sought to provide the Trust board with assurance in relation to the Trust's EPRR arrangements, and compliance in relation to the Civil Contingencies Act. Emergency preparedness and major incident arrangements were considered to be particularly strong, with a robust series of testing undertaken. Whilst well-rehearsed business continuity arrangements exist for the clinical areas in relation to power failures and ICT downtime, broader directorate and divisional business continuity plans need further work. The Trust board noted the report, and confirmed that it provided appropriate assurance in relation to EPRR arrangements. It was noted that the business continuity plans would be reviewed by ARG once revised.	
4.4	**St Mary's Hospital redevelopment – public exhibition** Michelle Dixon reported on the public exhibition held on 8-10 September, which enabled visitors to view the display of proposals on a set of ten boards and meet the development project team along with Trust clinicians and managers. The exhibition received a total of 239 visitors. Feedback was generally positive, particularly in the improvements in patient environment and experience, and the overall design. A programme of actions was now being developed. The Trust board noted the report.	
5	**Items for information**	
5.1	**Single oversight framework** Jan Aps introduced the paper on the single Oversight Framework which would replace the Accountability Framework (from 1 October 2016) by which individual trust's performance had previously been assessed. Arrangements were in place to ensure that the Trust scorecard and other monitoring processes were fully aligned with the new requirements. The Trust board noted the report.	
5.2	**Annual workforce equality report**	

	David Wells introduced the paper which provided an overview of key workforce equality metrics for the previous year, noting that the information within the report was used to monitor progress and to provide information for future actions to promote equality and combat discrimination. Responding to a question from Sarika Patel he commented that the diversity observed was more a reflection of the diversity of the local population than the overseas recruitment undertaken by the Trust. Peter Goldsbrough expressed concern at the level of staff reporting harassment (28% of white staff, and 35% BME staff); David Wells commented that this did not correlate with the recent wider staff survey – David Wells would provide further information. The Trust board noted the report.	**DW**
6	**Board committee reports**	
6.1	The Trust board noted the report from the board committees as follows: • Finance and investment committee (19 August/ 21 September) • Redevelopment committee (27 July / 21 September).	
7	**Any other business**	
	There were no items of any other business.	
8	**Questions from the Public relating to agenda items** In responding to questions from the public, the following key points were made by Trust board members: • The Trust expected to submit a planning application for the new outpatient building to Westminster Council before Christmas 2016; it would be subject to the standard planning processes. • Noting specific concerns from a member of the public, details were taken for the PALS team to take forward, and ensure that lessons were learned. • Recognition of how hard staff were working was welcomed. However, whilst working efficiently within the existing models, fundamentally new models of care and ways of working were required to bring about the necessary scale of changes required. • The Sustainability and Transformation Plan gave a direction of travel towards the vision outlined in the five-year forward view; this would move the NHS away from focussing on how to treat patients once they arrived at hospital and work more effectively at keeping them healthy and/or treating them in more appropriate settings.	
9	**Date of next meeting**	
	Public Trust board, 30 November 2016: W12, Hammersmith Hospital – start time to be confirmed – approximately 11.30	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

Record of items discussed at the confidential Trust board meetings on 28 September and 23 November 2016

Executive summary:

Decisions taken, and key briefings, during the confidential sessions of a trust board are reported (where appropriate) at the next trust board held in public.
Issues of note and decisions taken at the Trust board's confidential meetings held on 28 September and 23 November 2016:

NHS Improvement Control Total and Financial Improvement Programme
The Trust board approved the submission, to NHS improvement, of a letter signing up to the control total (an additional in-year financial stretch target of £11m) expressing appropriate caveats in the letter of acceptance.

Strategic outline case for the phase 1 redevelopment of St Mary's Hospital
In line with the development demonstrated at the public exhibition in September, the Trust board approved the strategic outline case and supported the onward submission of the case for a new outpatient facility to NHS Improvement.

Partnership working with Chelsea & Westminster NHS Foundation Trust
The Trust board noted a report outlining the agreement for a shared Cerner electronic patient record between Imperial and ChelWest, which would enable improved patient care through a shared patient record, and deliver significant savings as economies of scale were realised.

Submission of draft Business Plan 2017-19
The Trust board discussed the recommendation from the finance and investment particularly committee that the draft plan to be submitted did not achieve the proposed control total. The Trust board also noted that the assumptions submitted for the Sustainability and Transformation Plan (STP) had been revisited. Noting that discussions continued with commissioners as to affordability of expected activity levels, and internally as to the appropriate scale of stretching but achievable CIPs, the Trust board supported the recommendation and approved the submission of a draft business plan did not achieve the proposed control total. It was noted that the draft plan was required to be submitted on 24 November.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellence leadership, efficient use of resources, and effective governance.

Author	Responsible executive director
Jan Aps, Trust company secretary	Tracey Batten, Chief executive

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status	Update (where action not completed)
Workforce equality report: To provide further information on the apparent variation in reporting of staff reporting harassment between the national and local surveys	September 2016	David Wells	In hand	This will be addressed in the December board seminar

MATTERS ARISING

Minute Number	Action /issue	Responsible	November 2016 Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

Patient Story

Executive summary:

Patient stories are seen as a powerful method of bringing the experience of patients to the Board. Their purpose is to support the framing of patient experience as an integral component of quality alongside clinical effectiveness and safety.

This month's patient story focuses on the contribution made by patients to the trust's patient and public involvement (PPI) work. Garry, who has been a patient here for over 20 years, will talk about his experience of being an active participant in PPI activities. Garry's story will be presented in a video.

Quality impact:

The Trust board will hear how the patient and public involvement work can have a beneficial outcome for patients who participate. This paper is relevant to the caring and responsive CQC domains.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

Failure to include users of trust services in their development and oversight can result in these services being less responsive than that might otherwise be.

Recommendation to the Trust board:

The Trust board is asked to note this paper and the patient story

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Guy Young	Janice Sigsworth	24 November 2016

Patient Story

1. Background

The use of patient stories at board and committee level is increasingly seen as positive way of reducing the "ward to board" gap, by regularly connecting the organisation's core business with its most senior leaders. There is an expectation from both commissioners and the NHSI that ICHT will use this approach.

The perceived benefits of patient stories are:

- To raise awareness of the patient experience to support Board decision making
- To triangulate patient experience with other forms of reported data
- To support safety improvements
- To provide assurance in relation to the quality of care being provided (most stories will feature positive as well as negative experiences) and that the organisation is capable of learning from poor experiences
- To illustrate the personal and emotional sequelae of a failure to deliver quality services, for example following a serious incident

The Board has previously approved the patient and public involvement strategy, a key part of which is engagement with users of our services and increasing the number of patients who are actively involved. Garry has for many years been actively involved in patient forums in the trust and will relate his experiences of that. The Board has also previously approved a multi-method approach to hearing patient stories and Garry will tell his story in a video. This is the first time the Board will have had a video story and feedback on this method would be welcomed.

2. Garry's Story

Garry was diagnosed HIV positive at St Mary's in 1994. At this time the prognosis for patients with HIV was poor and Garry was given two years to live. Although that now appears to have been a pessimistic outlook, Garry has been an inpatient in our hospitals 54 times since then. His condition improved significantly in the late 1990s and in a desire to give something back to the Trust for the care he had received, he joined the patient forum in the clinic he attended. Over a relatively short period of time he became the chair of that forum and, as people moved on, the sole patient representative.

In this video, which was also shown at the recent lay partner involvement session, Garry will talk about what prompted him to become actively engaged, the benefits and some of the pitfalls of being a patient representative. He will talk about how it can be difficult to get others to get involved in PPI work and offer advice to potential volunteers.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	30 November 2016

Chief Executive's Report

Executive summary:

This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust. It will cover:

Key strategic priorities:

1) Financial performance
2) The Trust's financial improvement programme
3) Operational performance
4) Stakeholder engagement
5) Improving urgent and emergency care services and managing extra winter demand
6) Junior Doctor contract
7) CQC re-inspection of Outpatients and Diagnostic Imaging
8) National Institute for Health Research Funding Award

Key strategic issues:

1) St Mary's Hospital redevelopment plans
2) North West London Sustainability and Transformation Plan
3) North West London Pathology

Quality impact:

N/A

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust Board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.
As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.
To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Tracey Batten	Tracey Batten, Chief Executive	23 November 2016

Chief Executive's report

Key Strategic Priorities

1. Financial performance

In September, the Trust agreed an improved financial plan with NHS Improvement (NHSI) for an outturn of a £41million deficit, an £11million improvement on the £52million deficit plan originally set for the 2016/17 financial year. The Trust is now eligible for Sustainability and Transformation Funding (STF) of £24.1million, which will be released by NHSI if agreed financial and performance targets are met.

For October 2016, the Trust reported an in-month deficit of £2.13million before STF, which was on plan for the month. Year-to-date (i.e. up to the end of October 2016), the Trust reported a deficit of £28.5million, before STF, £0.47million better than plan.

The Trust is forecasting to be on plan at the end of the year (i.e. up to the end of March 2017).

2. Financial improvement programme

The Trust continues to work in partnership with PwC to progress our financial improvement programme. They have supported the Trust in establishing a Project Support Office (PSO) which is driving efficiencies in the long-term and improving cost management across the organisation.

PwC is helping the Trust to develop the necessary skills and capability with our own staff so that the financial improvement programme is sustainable when PwC support ends. You will note that the Chief Financial Officer's report on the November Trust board agenda states that the cost improvement plan programme is behind plan by £1.8million as of the end of October 2016. The Trust is working to make sure that this gap is closed while also maintaining its continued focus on the safety and quality of clinical services.

3. Operational Performance

Cancer: In September 2016 the Trust achieved five of the eight national cancer standards. The Trust underperformed against the two week wait from GP referral to first outpatient appointment standard, the 62-day GP referral to first treatment standard and the 62-day GP referral to screening standard. The Trust continued to receive a sustained increase in numbers of late referrals from other North West London sites and continued to see delays in colorectal and urological diagnostic pathways. Recovery plans and timescales are agreed between the Trust, CCG and NHS Improvement.

Accident and Emergency: Performance against the 95% four hour access standard for patients attending Accident and Emergency was 87.0% in October 2016. This met the revised performance trajectory target for the month. The Trust continues to work closely with partners across the local health system to recover performance. Please refer to section 5 of this report for a number of actions the Trust is taking to address increasing demand for our accident and emergency services.

Referral to treatment (RTT): The performance for October 2016 was 83.4% (September performance was 81.6%) against a standard of 92 per cent of patients being treated within 18 weeks of referral. The Trust continues the work of its waiting list improvement team and action plan, with external expert advice and support, to ensure we return to delivering the RTT standard sustainably. As part of this programme a data clean-up exercise is being carried out that has identified a significant number of patients waiting over 52 weeks for

treatment. In October, the number of patients waiting over 52 weeks was 475. The priority is to agree a date for treatment for each patient as soon as possible. Each patient is subject to a clinical review to make sure that their care plan is appropriate in view of the time they have waited for treatment.

Diagnostic waiting times: In October 2016, 0.24% per cent of patients were waiting over six weeks against a tolerance of 1 per cent, therefore achieving the standard.

4. Stakeholder engagement

We were delighted to welcome His Royal Highness The Prince of Wales to St Mary's Hospital in October, to meet four nurses from the Trust who were shortlisted for the Nursing Times Awards 2016. The Prince met the shortlisted nurses, as well as other nursing staff and patients as he toured two wards: Charles Pannett, which specialises in caring for patients with bowel and upper gastro-intestinal conditions including cancer, and the intensive care unit which looks after the most seriously ill patients. His Royal Highness also received a demonstration of a new app developed by nurses at the Trust to help prevent pressure ulcers.

We have continued our regular programme of stakeholder engagement. In November, I met with the local MPs for Westminster and Hammersmith constituencies Karen Buck, Rt Hon Mark Field and Andy Slaughter to discuss Trust issues and developments. Mark Field also visited St Mary's Hospital for a site walk-around to discuss our phased redevelopment plans. We met with Councillor Vivienne Lukey and director of adult social services Liz Bruce from the London Borough of Hammersmith and Fulham in October. We also met with representatives of Save our Hospitals in November. Engagement on the proposed phase one redevelopment of St Mary's Hospital has continued including the submission of a report and attendance at the November meeting of Westminster City Council's Adults, Health and Public Protection Policy and Scrutiny Committee.

The Trust's strategic lay forum held another of its regular meetings in October. We also organised an event in November at St Paul's Church in Hammersmith to develop our lay partner involvement, working with clinicians and managers to help shape and oversee the development and implementation of our strategies, programmes and projects.

In addition, the Trust's three bi-monthly electronic newsletters for stakeholders, GPs and shadow foundation trust members were published in October.

5. Improving urgent and emergency care services and managing extra winter demand

There is growing demand for the Trust's urgent and emergency services and care pathways, particularly over the past few months:

- Type 1 (the most serious) A&E attendances for the three months to October 2016 are up 10.2% at St Mary's and 12.5% at Charing Cross, compared with the same period last year overall
- A&E attendances are up by 2.9% at St Mary's and 7.9% at Charing Cross over the period
- The number of patients arriving at A&E by ambulance has increased by 11.7% (14.7% at St Mary's and 7.7% at Charing Cross) over the period
- A&E attendances at The Western Eye are up 5.9% over the period.

Despite huge efforts, this is having an impact on how quickly we can see and treat patients and on our capacity for planned care. In order to address these challenges the Trust has an on-going programme of developments to improve our whole urgent and emergency care pathway as well as initiatives to manage the further anticipated increase in demand through the winter months. This report gives some examples of this work:

Ambulatory emergency care (AEC) changes

- The Trust is extending operational hours for ambulatory emergency care services at St Mary's and Charing Cross to help avoid unnecessary hospital admissions.
- The services are closely integrated with the medical and surgical teams in the emergency department and provide specialist diagnostics and treatment for patients who have urgent needs but are well enough to go home in between procedures or consultations – essentially, to be cared for on an urgent outpatient basis.
- The AEC has been operating at St Mary's and Charing Cross since 2012/13 when it started as two small scale pilots, which have been running successfully on weekdays since.
- The Trust is now working towards opening hours of 08.00-22.00, Monday-Friday, and 08.00-20.00 at weekends.
- During the week ending 6 November 2016, the ambulatory emergency care unit at St Mary's cared for – and potentially avoided unnecessary inpatient admissions for – 190 patients in total, including 32 patients over the weekend.

Charing Cross pathway improvements

- The Trust is bringing together all acute medicine services and developing an acute assessment unit (AAU) to provide a more streamlined pathway for urgent and emergency patients, enabling faster access to the right specialist opinion where required. It will involve the creation of a new 13-space AAU on the current South Green ward (from January 2016) and the formation of a single 35-bed acute admissions ward on the ground floor of the hospital (from late November 2016).

St Mary's pathway improvements

- The Trust is creating a 12-space surgical assessment unit in the Paterson Building to improve the urgent and emergency care pathway and enable faster access to the right specialist opinion where required. The unit is due to be operational by late December.
- Refurbishment of the A&E department is almost half way through. The resus area has been moved to a temporary location as planned and work is underway to build the new, expanded resus and rapid assessment area.
- Resus is due to open in February 2017 and the refurbishment project is due to complete in April 2017.

6. Junior Doctor Contract

The British Medical Association has withdrawn its proposed junior doctors' industrial action in response to the introduction of the new junior doctors' contract from October 2016. The Trust has continued to work positively with our junior doctors and wider workforce to plan effectively for the introduction of the new contract. We have held three open forums with Junior Doctors to discuss the implications of the new contract and how we can work together to resolve any issues.

7. CQC re-inspection of Outpatients and Diagnostic Imaging

The CQC re-inspected our Outpatient and Diagnostic Imaging services between 22 and 24 November 2016. This follows the CQC Trust inspection in September 2014 where the Trust received an overall rating of requires improvement. The Trust is expecting to receive formal feedback from the CQC visit early in the new year.

8. National Institute for Health Research Funding Award

I am pleased to confirm that we are one of eight London trusts to share more than £40million in National Institute for Health Research investment over the next five years. Imperial has been awarded £10.88million which represents steady state funding for the

Trust and we continue to remain the largest in terms of the NIHR award in London.

London's funding is part of a £112million national investment into clinical research facilities across the country. 23 NHS organisations in total across the country have been given a share of funding to support clinical research and trials.

Key Strategic Issues

1. St Mary's Hospital redevelopment plans

The Trust continues to work on its phase 1 redevelopment plan for St Mary's Hospital. There are some important timelines to meet in the coming weeks including our submission of the detailed planning application for the new outpatient facility in mid-December 2016. The Trust is anticipating that the planning application would be considered by Westminster City Council in spring 2017.

2. North West London Sustainability and Transformation Plan (NWL STP)

On Friday 21 October 2016, the NWL sustainability and transformation plan was submitted to NHS England. This builds on further work, and feedback received, since the first draft was submitted to NHS England on Thursday 30 June 2016.

The STP sets out how local government and the NHS are working together to provide joined up services for residents in north west London. The STP is an 'umbrella' – covering local CCG commissioning plans plus larger scale and region-wide work. Most improvements will be developed and delivered locally, but the STP encourages greater coordination and cooperation across the health and care system, reflecting the way patients use it.

The latest version of the plan has been published at:

https://www.healthiernorthwestlondon.nhs.uk/news/2016/11/08/nw-london-october-stp-submission-published

A more detailed update on the NWL STP is on the Trust's Public board agenda today.

3. North West London Pathology (NWLP)

Further to the last update in the July 2016 Chief Executive report, NWLP continues to make good progress as it gets ready to be fully operational on 1 April 2017. It is an NHS owned joint venture between Hillingdon Hospitals NHS Foundation Trust, Chelsea and Westminster NHS Foundation Trust and our Trust which will provide pathology services across north west London through a new 'hub and spoke' model. Imperial will be the host provider for NWLP with the hub based at Charing Cross Hospital.

The combined pathology services will deliver 30 million tests per year and is estimated to be about 5-6% of the total pathology service in England.

From 1 January 2017, all Pathology staff working more than 50% of their time in Pathology will TUPE (transfer) to this Trust as the host for NWLP. This will mean that individuals employed by Hillingdon and West Middlesex (now part of Chelsea and Westminster) will be TUPE transferred to the employment of our Trust. One member of staff will transfer from our Trust to Chelsea & Westminster Hospital.

We have established an internal Transition Committee to oversee all the work required to make the transfer to NWLP successful.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**30 November 2016**

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of October 2016 (month 7).

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director
Terence Lacey (Performance Support Business Partner) Julie O'Dea (Head of Performance Support)	Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Jamil Mayet (Divisional Director) Tim Orchard (Divisional Director) Tg Teoh (Divisional Director)

Contents

1. Key indicator overviews 5

1.1 Safe 5

1.1.1 Safe: Serious Incidents 5
1.1.2 Safe: Incident reporting and degree of harm 6
1.1.3 Safe: Meticillin - resistant Staphylococcus aureus bloodstream infections (MRSA BSI) 8
1.1.4 Safe: Clostridium difficile 8
1.1.5 Safe: Venous thromboembolism (VTE) risk assessment 9
1.1.6 Safe: Avoidable pressure ulcers 10
1.1.7 Safe: Safe staffing levels for registered nurses, midwives and care staff 10
1.1.8 Safe: CAS alerts 12
1.1.9 Safe: Postpartum haemorrhage 12
1.1.10 Safe: Statutory and mandatory training 12
1.1.11 Safe: Work-related reportable accidents and incidents 13

1.2 Effective 14

1.2.1 Effective: National Clinical Audits 14
1.2.2 Effective: Mortality data 14
1.2.3 Effective: Mortality reviews completed 15
1.2.4 Effective: Recruitment of patients into interventional studies 15
1.2.5 Effective: Discharges before noon 15
1.2.6 Effective: Readmission rates 16
1.2.7 Effective: Outpatient appointments checked in and checked out 17

1.3 Caring 18

1.3.1 Caring: Friends and Family Test 18
1.3.2 Caring: Patient transport waiting times 19

1.4 Well-Led 20

1.4.1 Well-Led: Vacancy rate 20
1.4.2 Well-Led: Sickness absence rate 21
1.4.3 Well-Led: Performance development reviews 22
1.4.4 Well-Led: Doctor Appraisal Rate 22
1.4.5 Well-Led: General Medical Council - National Training Survey Actions 23
1.4.6 Well Led: Estates – maintenance tasks completed on time 23

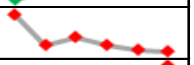
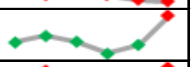
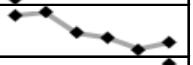
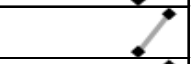
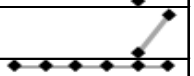
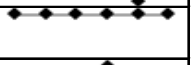
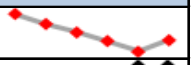
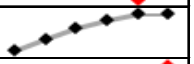
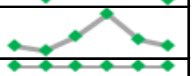
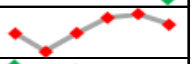
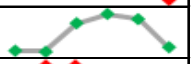
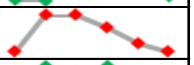
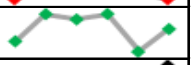
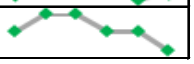
1.5 Responsive 25

1.5.3 Responsive: Consultant-led Referral to Treatment waiting times 25
1.5.4 Responsive: Cancer 27
1.5.5 Responsive: Elective operations cancelled on the day for non-clinical reasons 29
1.5.6 Responsive: Accident and Emergency 30
1.5.7 Responsive: Diagnostics 31
1.5.8 Responsive: Patient attendance rates at outpatient appointments 32
1.5.9 Responsive: Outpatient appointments cancelled by the Trust 32
1.5.10 Responsive: Outpatient appointments made within 5 days of receipt 33
1.5.11 Responsive: Access to antenatal care – booking appointment 34
1.5.12 Responsive: Complaints 35

2. Finance 35

Scorecard summary

Key indicator	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Oct-16	-	**17**	
Incidents causing severe harm (number)	Julian Redhead	Oct-16	-	**2**	
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Oct-16	-	**0.10%**	
Incidents causing extreme harm (number)	Julian Redhead	Oct-16	-	**1**	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Oct-16	-	**0.03%**	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Sep-16	44.0	**43.9**	
Never events (number)	Julian Redhead	Oct-16	0	**0**	
MRSA (number)	Julian Redhead	Oct-16	0	**1**	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Oct-16	23	**43**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Oct-16	95.0%	**95.5%**	
CAS alerts outstanding	Janice Sigsworth	Oct-16	0	**0**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Oct-16	-	**5**	
Staffing fill rates (%)	Janice Sigsworth	Oct-16	tbc	**97.1%**	
Post Partum Haemorrhage 1.5L (PPH) %	Tg Teoh	Oct-16	2.80%	**3.8%**	
Core training - excluding doctors in training / trust grades (%)	David Wells	Oct-16	90.0%	**86.0%**	
Core training - doctors in training / trust grades (%)	David Wells	Oct-16	90.0%	**59.3%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Oct-16	0	**2**	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Jun-16	100	**63.06**	
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Qtr 4 15/16	90.0%	**94.2%**	
Discharges before noon (downstream medicine)	Tim Orchard	Oct-16	35.0%	**16.7%**	
Unplanned readmission rates (28 days) for over 15s (%)	Tim Orchard	Apr-16	-	**6.58%**	
Unplanned readmission rates (28 days) for under 15s (%)	Tg Teoh	Apr-16	-	**5.86%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days) (number)	Tg Teoh	Oct-16	-	**3,013**	
Outpatient appointments checked-in AND not checked-out (number)	Tg Teoh	Oct-16	-	**3,952**	
Caring					
Friends and Family Test: **Inpatient** service % patients recommended	Janice Sigsworth	Oct-16	95.0%	**96.6%**	
Friends and Family Test: **A&E** service % recommended	Janice Sigsworth	Oct-16	85.0%	**93.1%**	
Friends and Family Test: **Maternity** service % recommended	Janice Sigsworth	Oct-16	95.0%	**92.6%**	
Friends and Family Test: **Outpatient** service % recommended	Janice Sigsworth	Oct-16	94.0%	**89.7%**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Oct-16	-	**71.7%**	

Key indicator	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Well Led					
Vacancy rate (%)	David Wells	Oct-16	10.0%	**10.3%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Oct-16	10.0%	**10.4%**	
Sickness absence (%)	David Wells	Oct-16	3.1%	**3.1%**	
Bank and agency spend (%)	David Wells	Oct-16	9.2%	**12.5%**	
Personal development reviews (%)	David Wells	Sep-16	95.0%	**86.2%**	
Non-training grade doctor appraisal rate (%)	Julian Redhead	Oct-16	95.0%	**73.5%**	
Staff FFT (% recommended as a place to work)	David Wells	Q1	-	**65%**	
Staff FFT (% recommended as a place for treatment)	David Wells	Q1	-	**83%**	
Education open actions (number)	Julian Redhead	Oct-16	-	**59**	
Reactive maintenance performance	Janice Sigsworth	Oct-16	98%	**71%**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Jamil Mayet	Oct-16	92.0%	**83.4%**	
RTT: 18 weeks Incomplete breaches - number of patients waiting	Jamil Mayet	Oct-16	-	**10624**	
RTT: Number of patients waiting 52 weeks or more	Jamil Mayet	Oct-16	0	**475**	
Cancer: 2-week GP referral to 1st outpatient - cancer (%)	Jamil Mayet	Sep-16	93.0%	**91.2%**	
Cancer: 2-week GP referral to 1st outpatient – breast symptoms (%)	Jamil Mayet	Sep-16	93.0%	**93.6%**	
Cancer: 31 day wait from diagnosis to first treatment (%)	Jamil Mayet	Sep-16	96.0%	**96.1%**	
Cancer: 31 day second or subsequent treatment (surgery) (%)	Jamil Mayet	Sep-16	94.0%	**95.7%**	
Cancer: 31 day second or subsequent treatment (drug) (%)	Jamil Mayet	Sep-16	98.0%	**100.0%**	
Cancer: 31 day second or subsequent treatment (radiotherapy) (%)	Jamil Mayet	Sep-16	94.0%	**95.6%**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Jamil Mayet	Sep-16	85.0%	**77.5%**	
Cancer: 62 day urgent GP referral to treatment from screening (%)	Jamil Mayet	Sep-16	90.0%	**86.0%**	
Cancelled operations (as % of elective activity)	Jamil Mayet	Sep-16	0.8%	**0.6%**	
28 day rebooking breaches (% of cancellations)	Jamil Mayet	Sep-16	5.0%	**8.5%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Oct-16	95.0%	**70.1%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Oct-16	95.0%	**87.0%**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Oct-16	1.0%	**0.2%**	
Outpatient Did Not Attend rate %: (First & Follow-Up)	Tg Teoh	Oct-16	11.0%	**11.3%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Oct-16	10.0%	**8.0%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Oct-16	95.0%	**76.4%**	
Antenatal booking 12 weeks and 6 days excluding late referrals (%)	Tg Teoh	Oct-16	95.0%	**97.0%**	
Complaints: Total number received from our patients	Janice Sigsworth	Oct-16	100	**86**	
Complaints: % responded to within timeframe	Janice Sigsworth	Oct-16	95%	**98.0%**	

1. Key indicator overviews

1.1 Safe

1.1.1 Safe: Serious Incidents

Seventeen serious incidents (SIs) were reported in October 2016. These are currently under investigation.

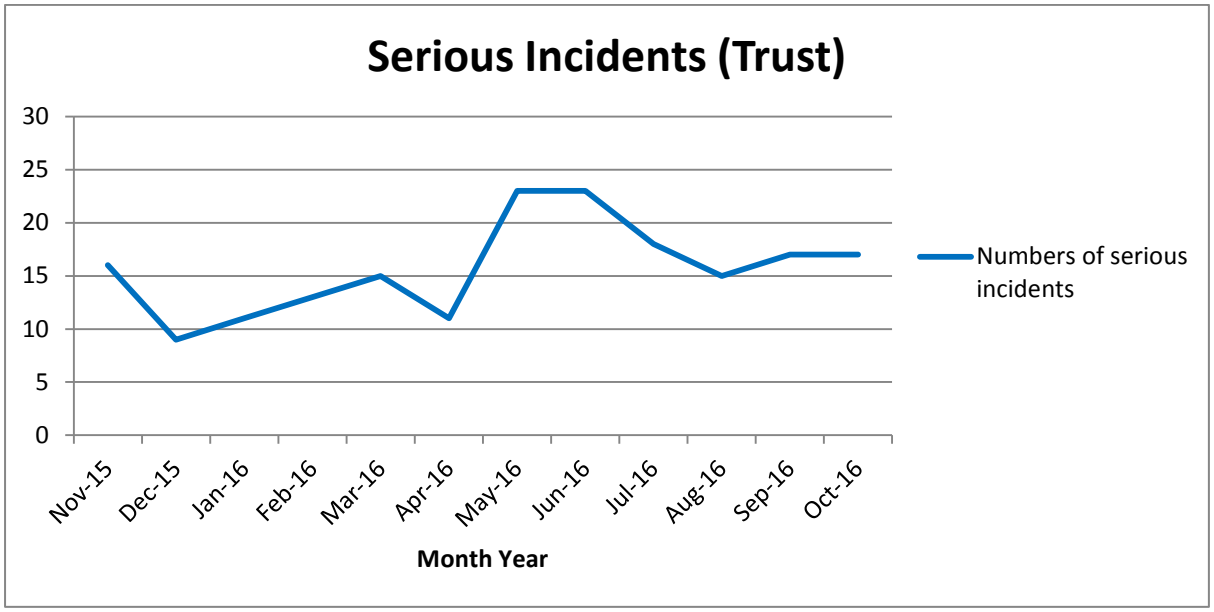


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period November 2015 – October 2016

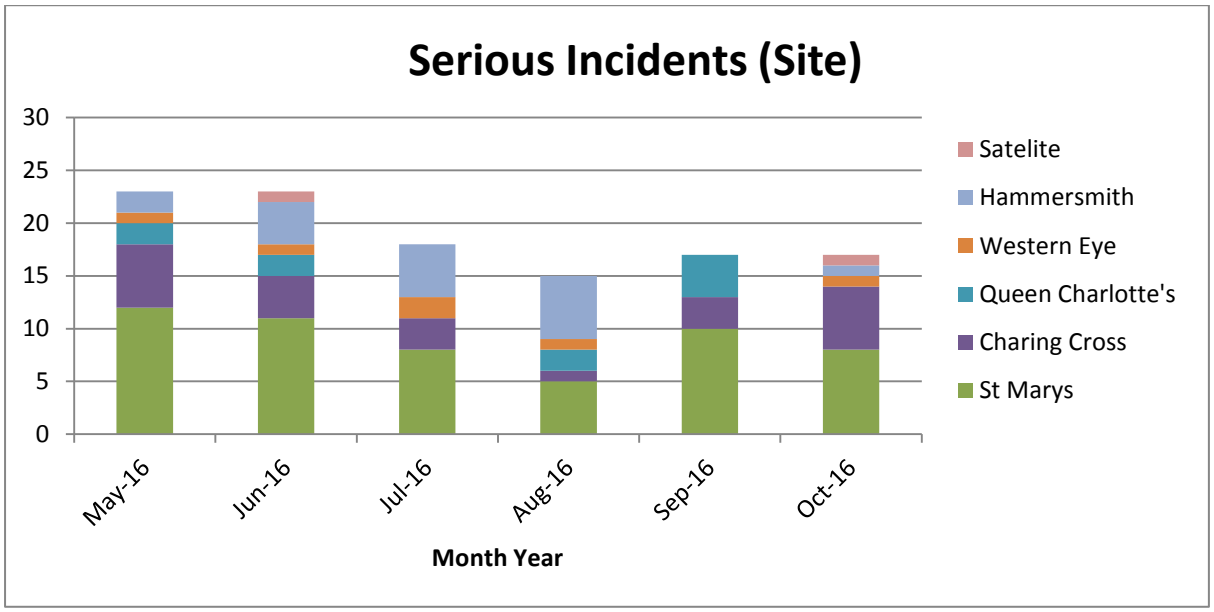


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period May 2016 – October 2016

1.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported two major/severe harm incidents and one extreme harm/death incident in October 2016.

The percentage of incidents causing these levels of harm reported by the Trust since April 2016 remains below national average as per the data published by the National Reporting and Learning System (NRLS) in September 2016.

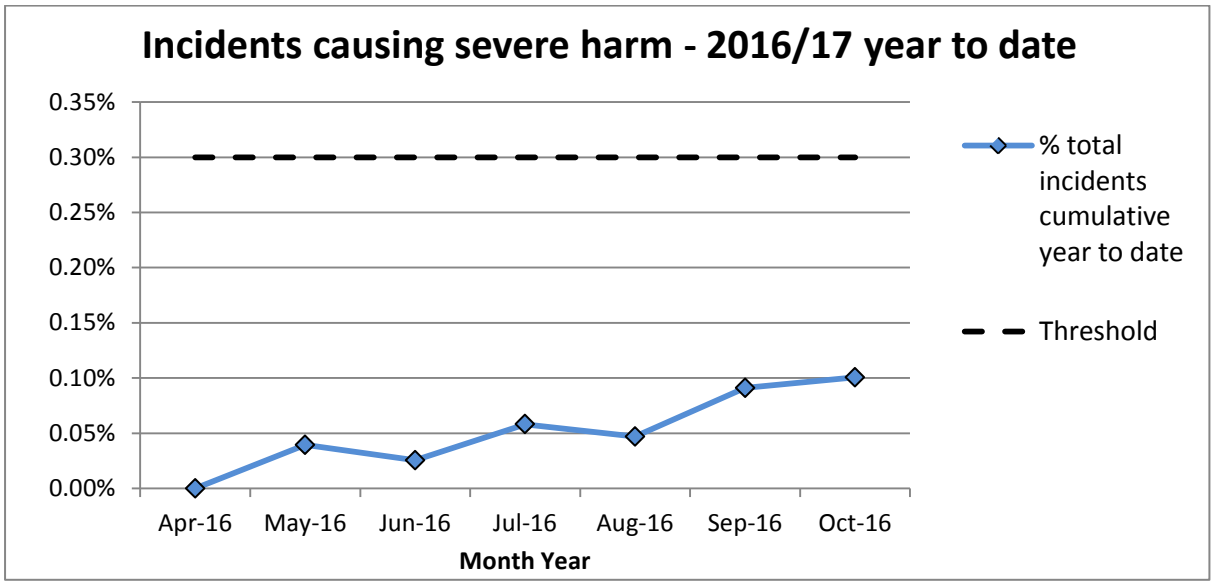


Figure 3 – Incidents causing severe harm by month from the period April 2016 – October 2016 (% of total patient safety incidents YTD)

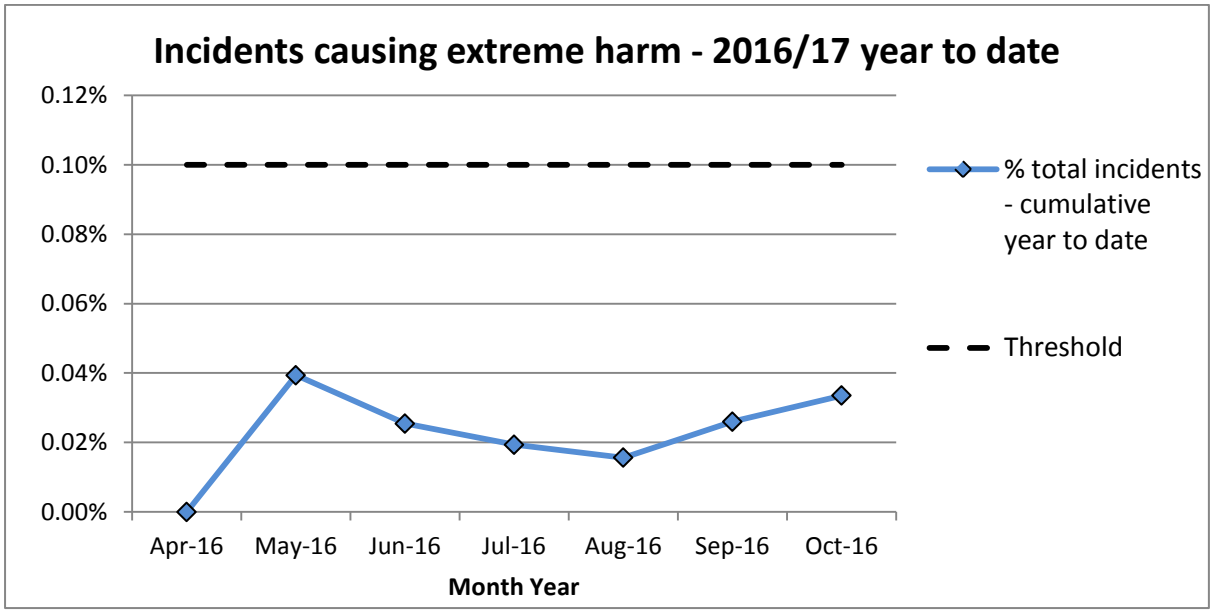


Figure 4 – Incidents causing extreme harm by month from the period April 2016 – October 2016 (% of total patient safety incidents YTD)

Patient safety incident reporting rate

Each month, all incidents reported on the Trust's incident reporting system (Datix) must be validated to confirm if they should be registered as a patient safety incident. A patient safety incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare. All patient safety incidents are sent to the National Reporting and Learning System and contribute to national statistics.

For the month of October 2016, validation has not been fully completed by all divisions so we are currently unable to report our patient safety incident reporting rate accurately. Performance for October has therefore not been included in figure 5 below.

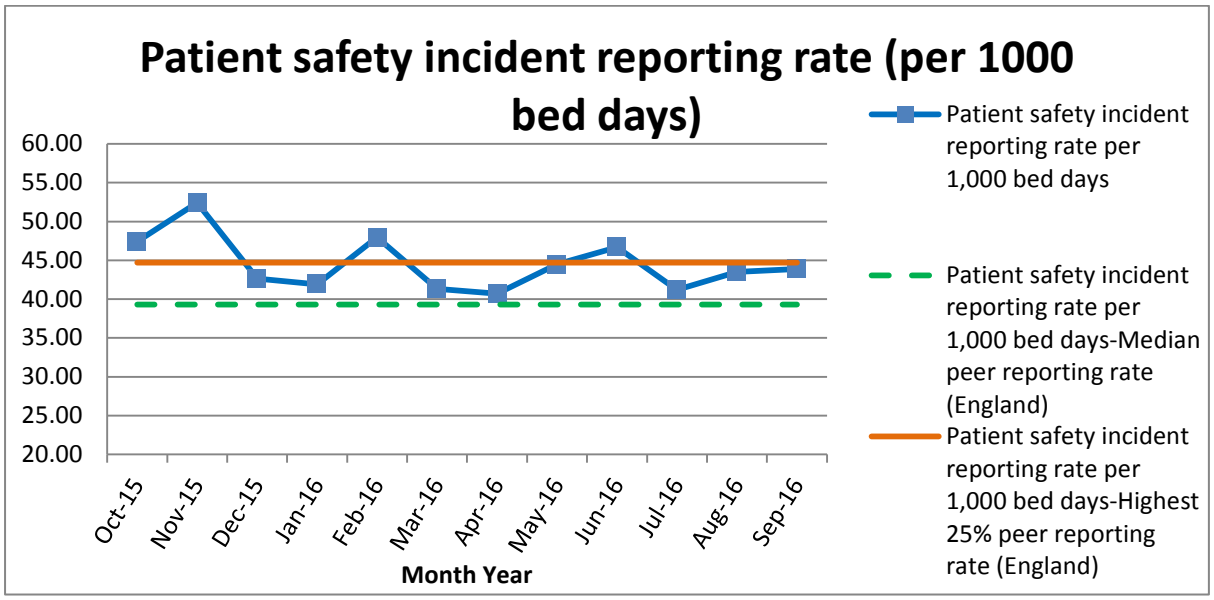


Figure 5 – Trust incident reporting rate by month for the period October 2015 – September 2016

(1) Median reporting rate for Acute non specialist organisations (NRLS 01/10/2015 to 01/03/2016)

(2) Highest 25% of incident reporters among all Acute non specialist organisations (NRLS 01/04/2015 to 30/09/2015)

Never Events

No never events were reported in October 2016, however one never event has been reported in November which occurred at Queen Charlotte's & Chelsea Hospital and was the result of an unintentionally retained vaginal swab. The incident is being investigated; immediate actions were taken by the division, including stopping staff changing over during emergency maternity procedures.

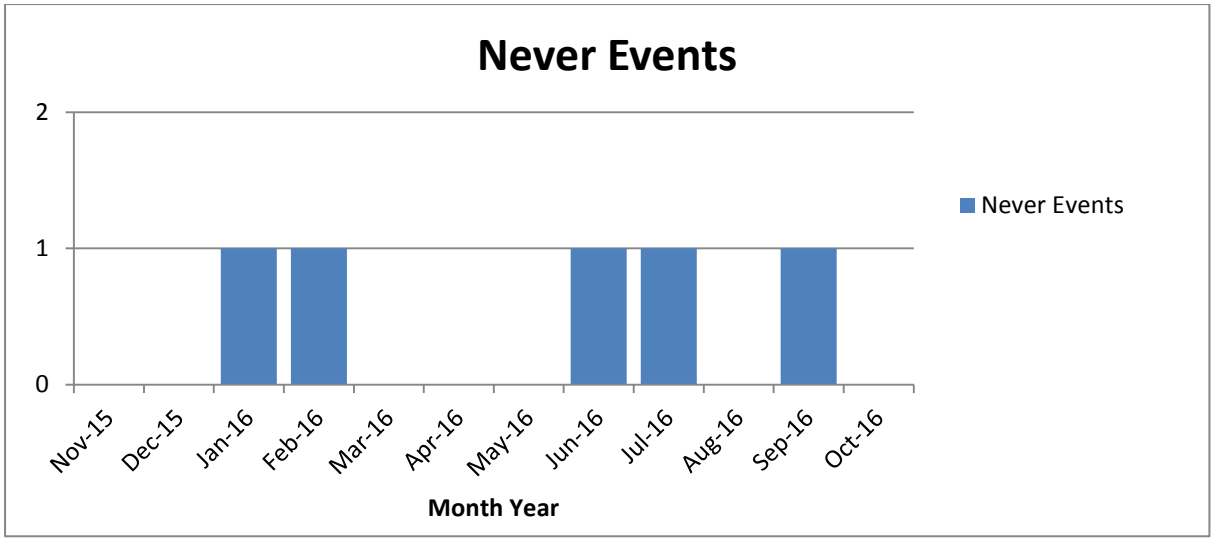


Figure 6 – Trust Never Events by month for the period November 2015 – October 2016

1.1.3 Safe: Meticillin - resistant Staphylococcus aureus bloodstream infections (MRSA BSI)

Seven cases of MRSA BSI have been identified at the Trust in 2016/17; two of these have been allocated to the Trust, one in May 2016 and one in October 2016. Each case is reviewed by a multi-disciplinary team. Actions arising from these meetings are reviewed regularly to identify themes. Contributory factors are addressed with the divisions via the taskforce weekly group meetings.

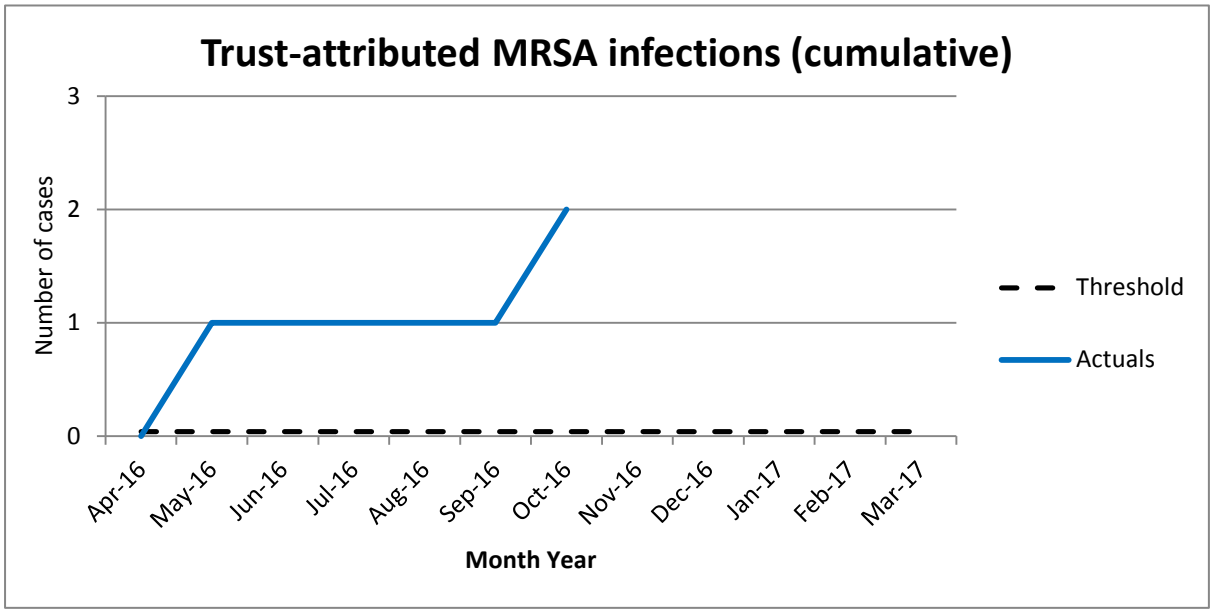


Figure 7 – Cumulative number of MRSA infections for the period April 2016 – October 2017

1.1.4 Safe: Clostridium difficile

Eight cases of *Clostridium difficile* were allocated to the Trust for October 2016. The site, ward locations and divisions of these cases are as follows:

- CXH – 8 North, 9 West, 4 South (MIC), 6 West (SCCS)

- HH – De Wardener (MIC), A8 (SCCS)
- SMH – Lewis Lloyd (MIC), Grand Union (WCCS)

The case on Lewis Lloyd Ward has been identified as a potential lapse in care related to a transmission event, which is awaiting confirmation by ribotyping.

A total of 43 cases have been allocated to the Trust in 2016/17, which is above the year to date threshold.

Each case is reviewed by a multi-disciplinary team to examine whether any lapses in care occurred. Actions from cases where a lapse of care is identified are reviewed through the Trust quality and safety sub-group.

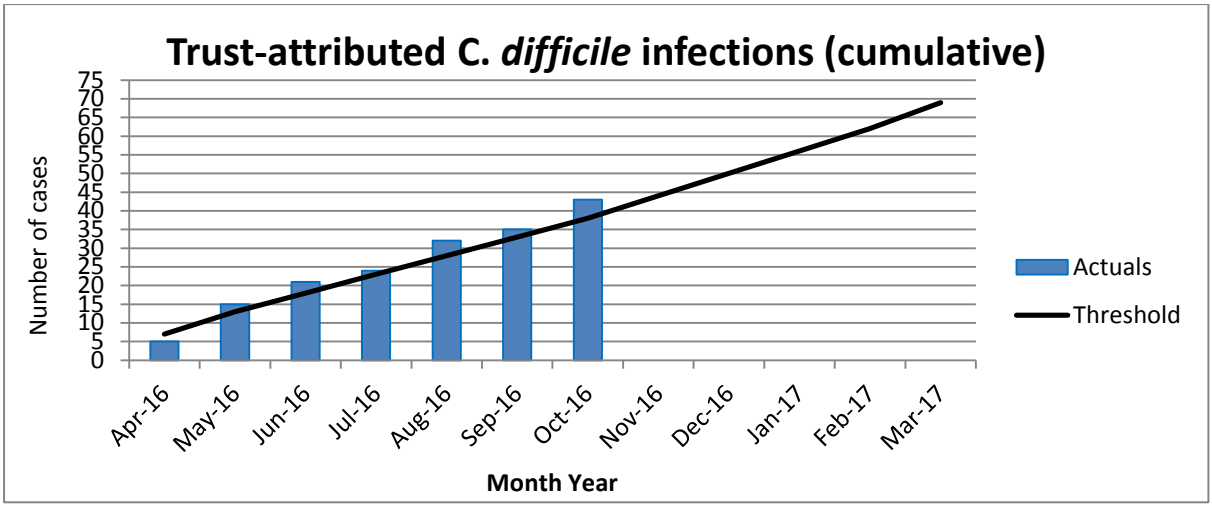


Figure 8 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2016 – October 2017

1.1.5 Safe: Venous thromboembolism (VTE) risk assessment

In October 2016, 95.55 per cent of adult inpatients (including day cases) were reported as being risk assessed for venous thromboembolism (VTE) within 24 hours of admission, against the national quality target of 95 per cent or more.

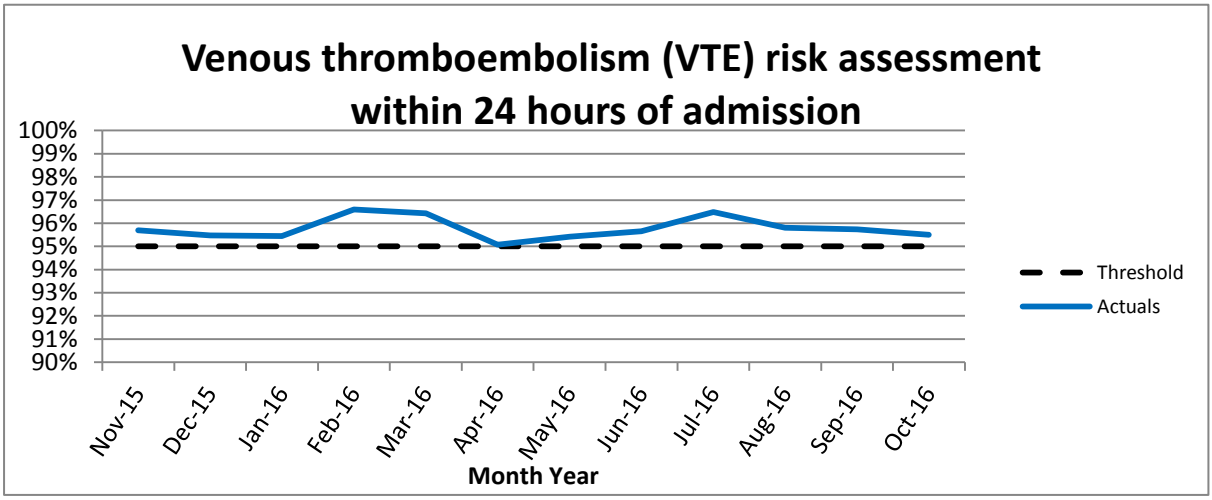


Figure 9 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period November 2015 – October 2016

1.1.6 Safe: Avoidable pressure ulcers

There were 5 avoidable pressure ulcers recorded in October 2016. A total of 17 have now been reported so far in 2016/17. The target is for a 10 per cent reduction on 2015/16 which equates to no more than 22. All pressure ulcers are reported as serious incidents and investigated by the Senior Nurse for the clinical area and local action plan implemented. No trust-acquired category 4 pressure ulcer has been reported since March 2013

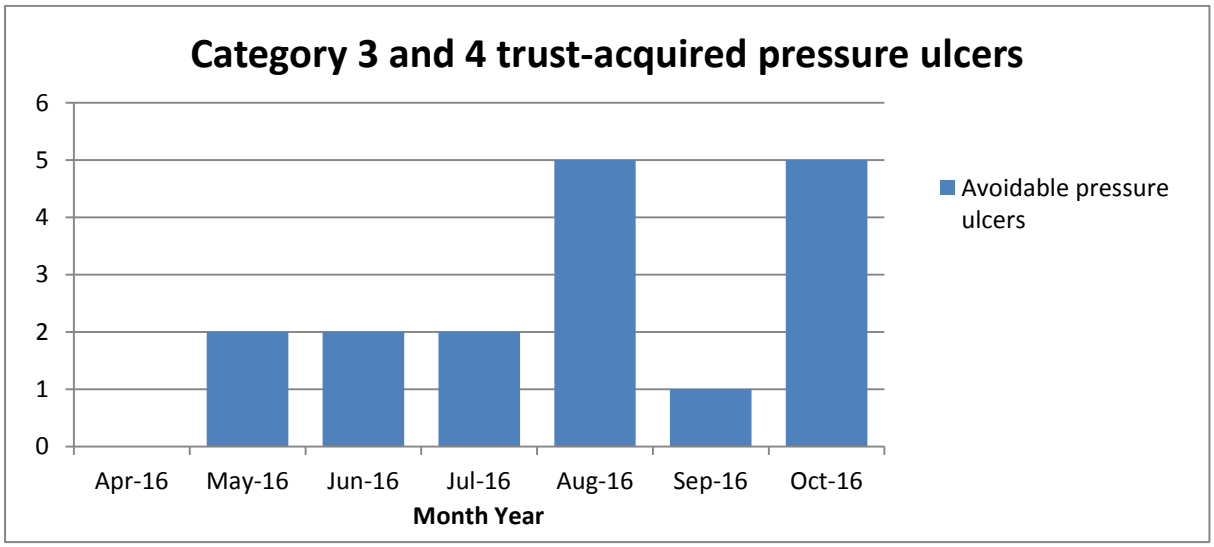


Figure 10 – Number of category 3 and category 4 (including unstageable) trust-acquired pressure ulcers by month for the period April 2016 – October 2016

1.1.7 Safe: Safe staffing levels for registered nurses, midwives and care staff

In October 2016 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff.

The percentage of shifts meeting planned safe staffing levels by hospital site are as follows:

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	97.37%	93.33%	98.29%	98.09%
Hammersmith	98.58%	94.76%	97.44%	98.54%
Queen Charlotte's	96.56%	93.48%	97.72%	97.52%
St. Mary's	96.88%	92.88%	97.60%	97.30%

The fill rate was below 85 per cent for care staff in the following ward:

- 5 South (critical care medicine) had a fill rate of 80 per cent for care staff during the day. This was due to an Ad-Hoc requirement for care staff on the unit for enhanced care, of which there were 7 shifts unfilled. These shifts were covered by staff being flexible on the unit to fill vacant shifts to ensure patients received the care they needed.

- There were no fill rates that fell below 90 per cent for registered staff in the month of October

In order to maintain standards of care the Trust's Divisional Directors of Nursing and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways:

- Using the workforce flexibly across floors and clinical areas and in some circumstances between the three hospital sites.
- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

In addition, the Divisional Directors of Nursing regularly review staffing when, or if there is a shift in local quality metrics, including patient feedback. All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in October 2016 were safe and appropriate for the clinical case mix.

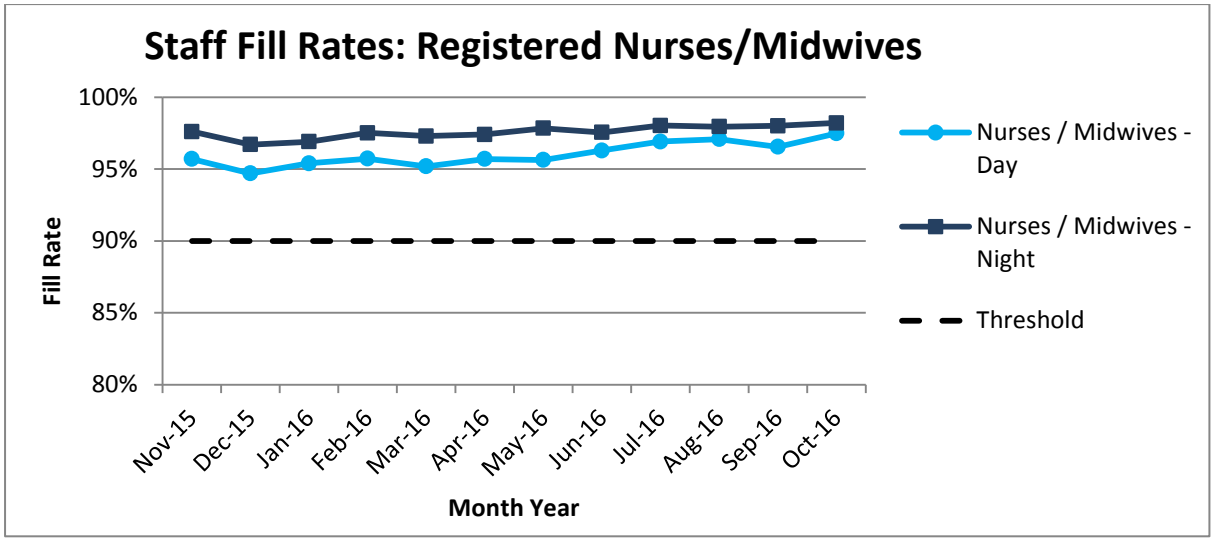


Figure 12 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period November 2015 – October 2016

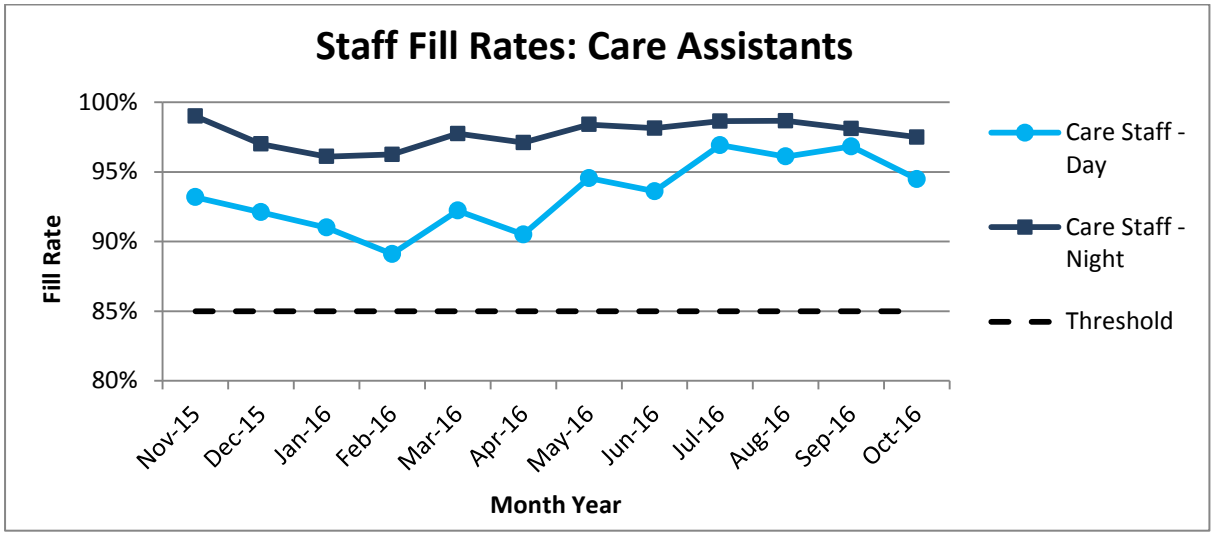


Figure 13 - Monthly staff fill rates (Care Assistants) by month for the period November 2015 – October 2016

1.1.8 Safe: CAS alerts

The Department of Health Central Alerting System (CAS) is a system for issuing patient safety alerts, public health messages and other safety critical information and guidance to the NHS and others.

At end October 2016 there were 0 overdue CAS alerts at the Trust. All open alerts are within their completion deadline dates.

1.1.9 Safe: Postpartum haemorrhage

In October 2016, 29 women who gave birth at the Trust had a postpartum haemorrhage (PPH), involving an estimated blood loss of 1500ml or more within 24 hours of the birth of the baby. This equates to 3.8 per cent of deliveries which is in line with the improvement trajectory target for the month of 3.9 per cent.

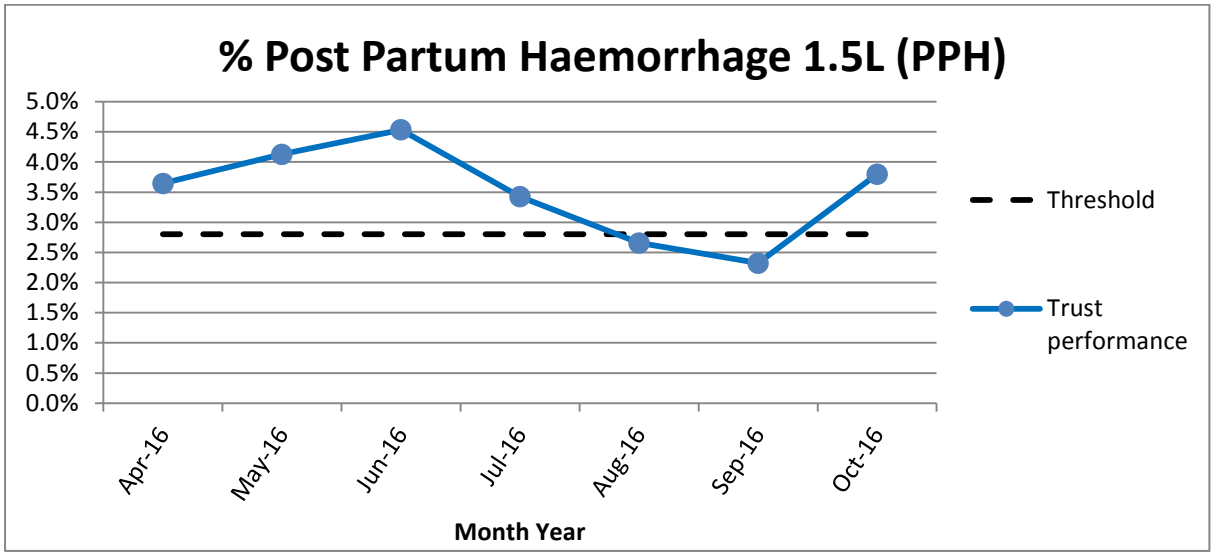


Figure 14 – Postpartum haemorrhage (PPH) for the period April 2016 – October 2016

1.1.10 Safe: Statutory and mandatory training

Core skills - excluding doctors in training / trust grade

In October 2016, overall compliance was 86.06 per cent against the target of 90 per cent or more. Work continues to improve compliance in the departments where performance is below target.

Core Skills for doctors in training / trust grade

In October 2016, overall compliance was 67.43 per cent against the target of 90 per cent or more. The compliance for junior doctors is currently below target. This is related to the London Streamlining Programme which did not produce any results in August and manual processes had to be implemented and doctors asked to repeat modules.

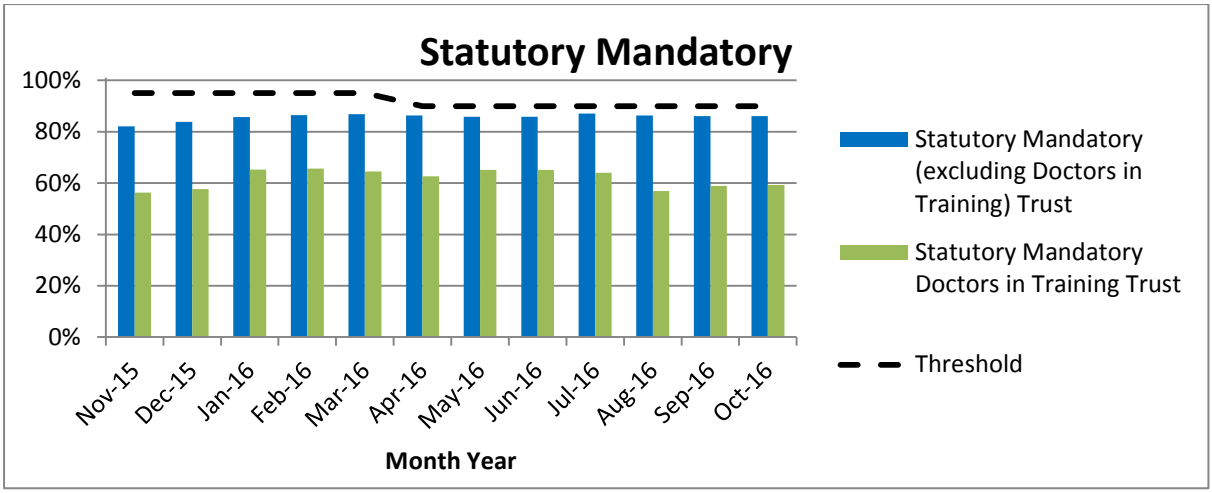


Figure 15 - Statutory and mandatory training for the period November 2015 – October 2016

1.1.11 Safe: Work-related reportable accidents and incidents

There was one RIDDOR-reportable incident (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) in October 2016.

- The incident was a nurse who received a sharps injury from a haemodialysis fistula needle during use on a Hepatitis C positive patient; this is reportable as a dangerous occurrence.

There was also one reported RIDDOR-reportable incident that occurred in April 2016, but reported in October 2016.

- The incident was during patient manual handling, resulting in a work related sickness absence of over 7 days. The incident was reported on Datix following return to work, after a number of month's absence, resulting in a late report to the HSE.

In the 12 months to 31 October 2016, there have been 36 RIDDOR reportable incidents of which 14 were slips, trips and falls. The Health and Safety service continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

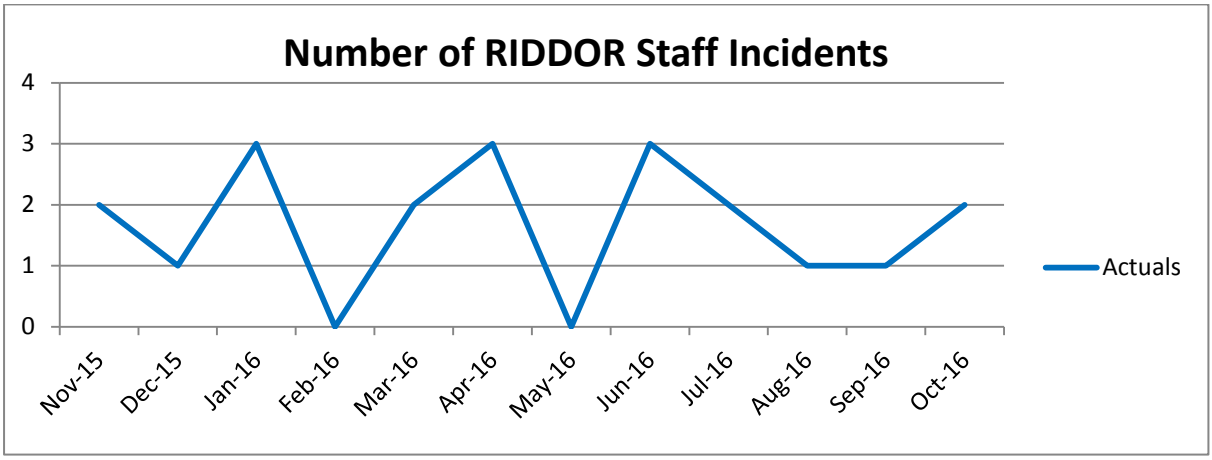


Figure 16 – RIDDOR Staff Incidents for the period November 2015 – October 2016

1.2 Effective

1.2.1 Effective: National Clinical Audits

The effective goal in our quality strategy for 2016/17 is to show continuous improvement in national clinical audits with no negative outcomes.

There have been 20 national clinical audit reports published since April 2016 in which the Trust participated. These are reviewed by the relevant division and a template completed by the audit lead. Of the 20 published audits, 9 audit report summary templates have been completed by the audit leads, with the remaining 11 are still under review by the divisions.

Where an audit indicates areas for improvement, the service is required to develop an action plan which is monitored by the divisional governance team and reported through the Directorate and Divisional Quality and Safety Committees; this process is overseen by the Clinical Audit and Effectiveness Group.

1.2.2 Effective: Mortality data

Our target for mortality rates in 2016/17 is to be in the top five lowest-risk acute non-specialist trusts as measured by the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI). The most recent monthly figure for HSMR is 63.06 for June 2016. Across the last year of available data (July 2015 – June 2016), the Trust has the third lowest HSMR for acute non-specialist trusts nationally. The Trust has the fourth lowest SHMI of all non-specialist providers in England for 2015/16.

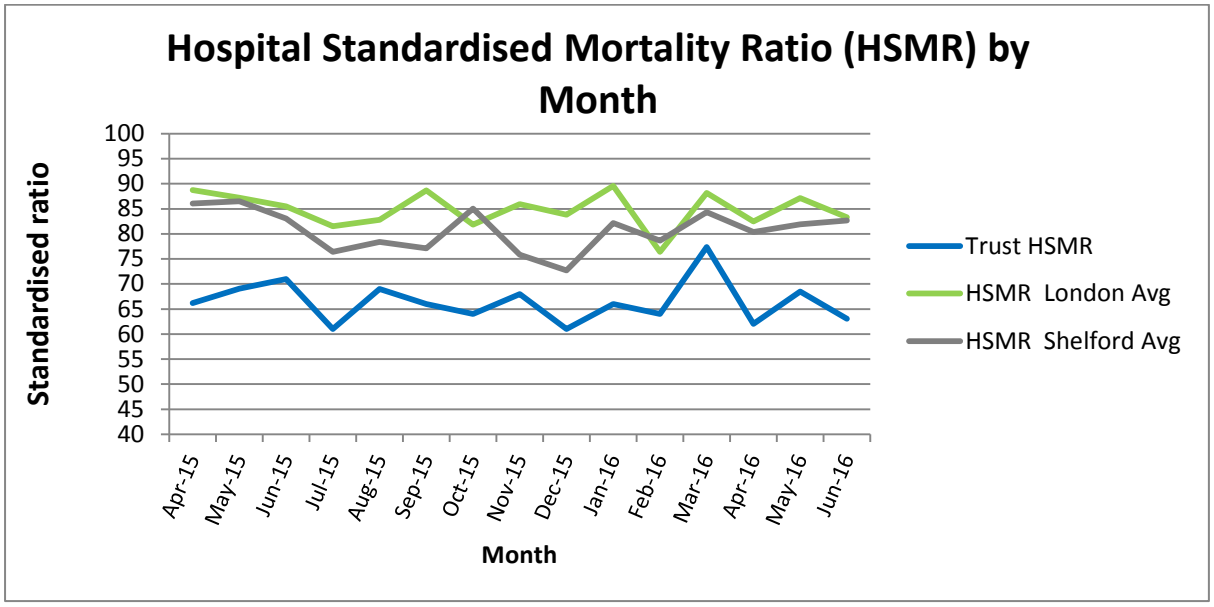


Figure 17 - Hospital Standardised Mortality Ratios for the period April 2015 – June 2016

1.2.3 Effective: Mortality reviews completed

In February 2016, the Trust introduced a new online mortality review process to standardise the way all deaths are reported and reviewed. This allows reporting of avoidable mortality in line with national guidance issued by NHS England.

Eighty five per cent of deaths occurring in the Trust between April-September 2016 have been reviewed by the divisions. Twelve deaths were categorised as possible avoidable deaths. Seven of these have been fully investigated: three have been confirmed as avoidable as result. A large retrospective note review exercise conducted across acute hospital trusts in England concluded that 3.6 per cent of deaths across the NHS were avoidable[1]; in an organisation this size that equates to 55 deaths a year.

1.2.4 Effective: Recruitment of patients into interventional studies

In quarter 1 2016/17, 94.2 per cent of clinical trials recruited their first patient within 70 days of a valid research application, against an internal target of 90 per cent.

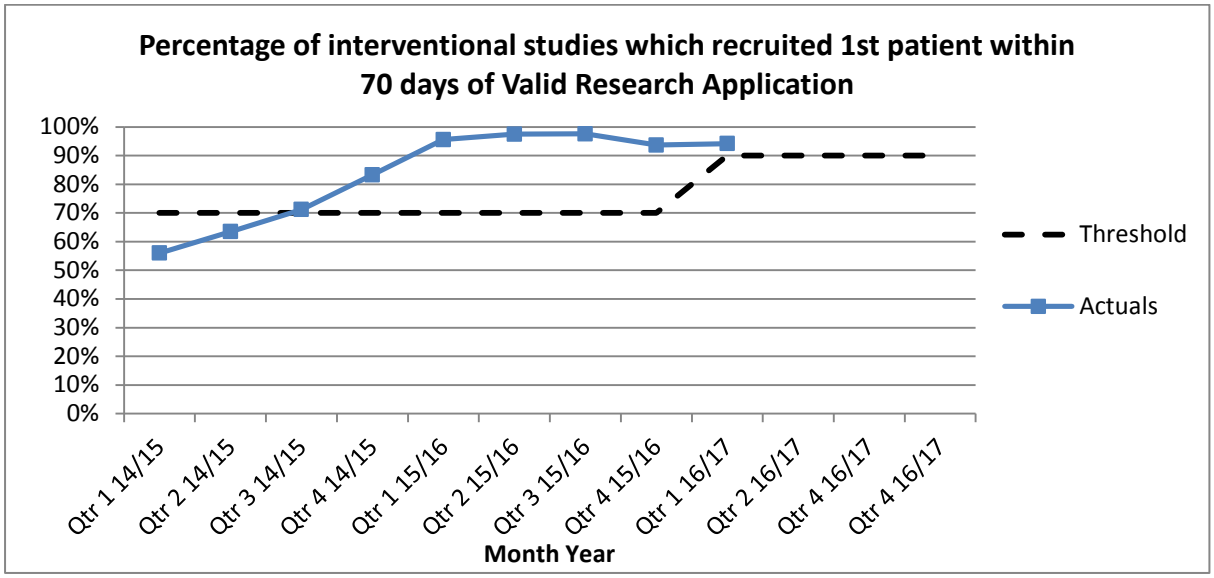


Figure 18 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q4 2015/16

1.2.5 Effective: Discharges before noon

During October the performance of discharges before noon remained below target. There was reduced discharge unit capacity at SMH as the unit was closed for bedded patients for a period to support overnight stays allowing only ambulant patients in a single bay. The CXH unit remains as part of the transport area until end of November and will be reopening to bedded model, located on 5 South.

[1] Hogan H, Zipfel R, Neuburger J et al. (2015) Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. The British Medical Journal. 351:h3239

The Playing our Part programme has been launched with the aim of identifying and addressing delays in patient flow and earlier identification of suitable patients for discharge before noon.

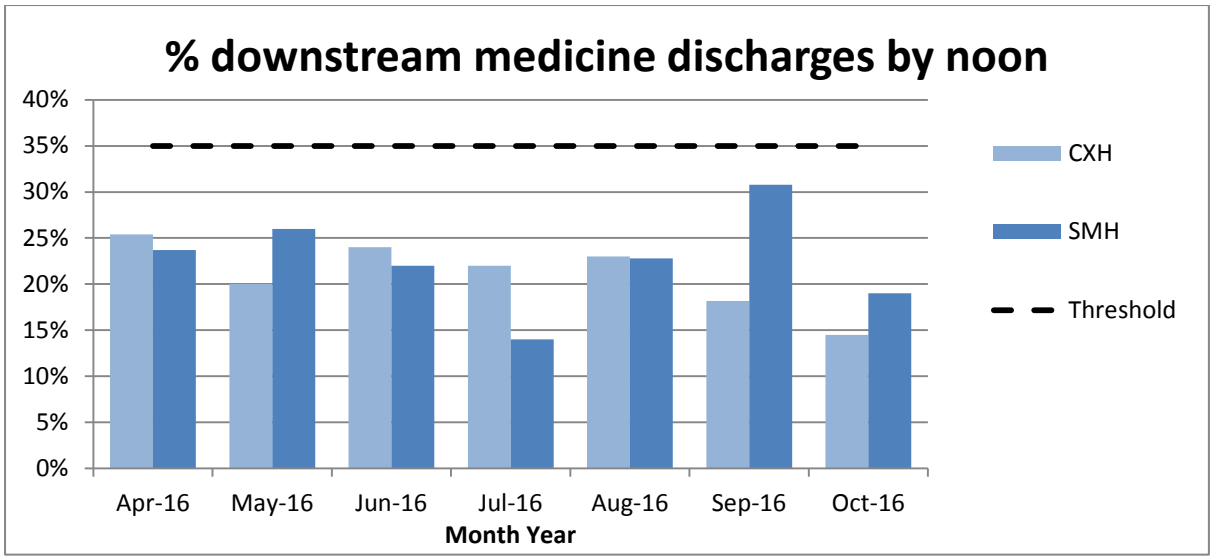


Figure 19 - Patients discharged from downstream medical wards before noon for the period April 2016 – October 2016

1.2.6 Effective: Readmission rates

The Trust target is to reduce unplanned readmissions after discharge from the Trust and be below the national average. The most recent monthly figure is for April 2016 because of the time lag involved.

For April 2016, Imperial readmission rates are lower in both age groups than the Shelford and National rates.

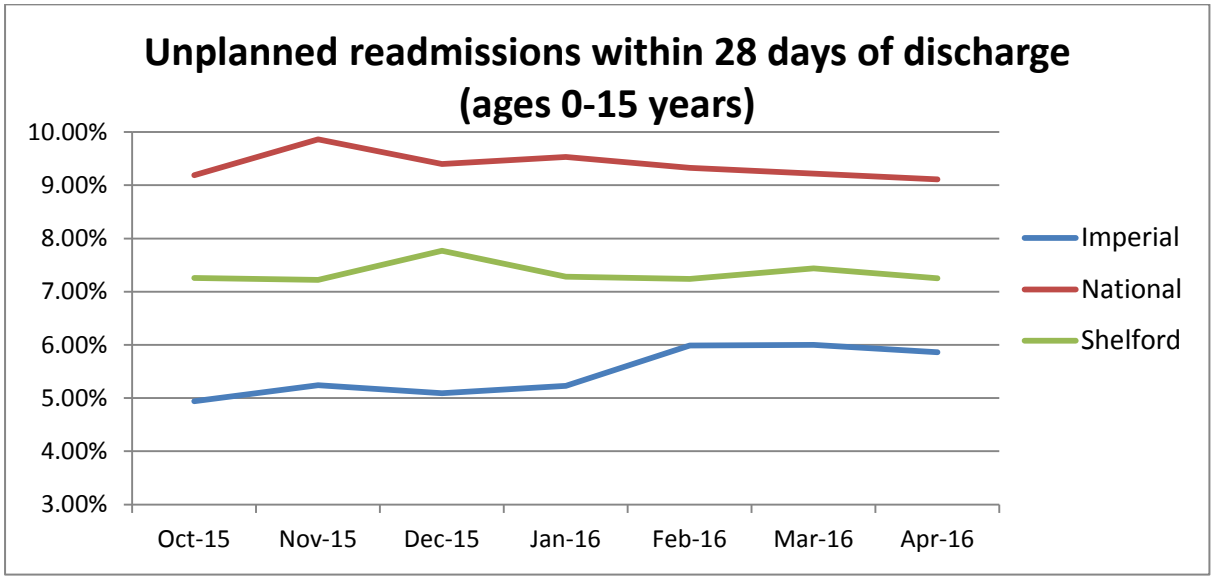


Figure 20 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – April 2016

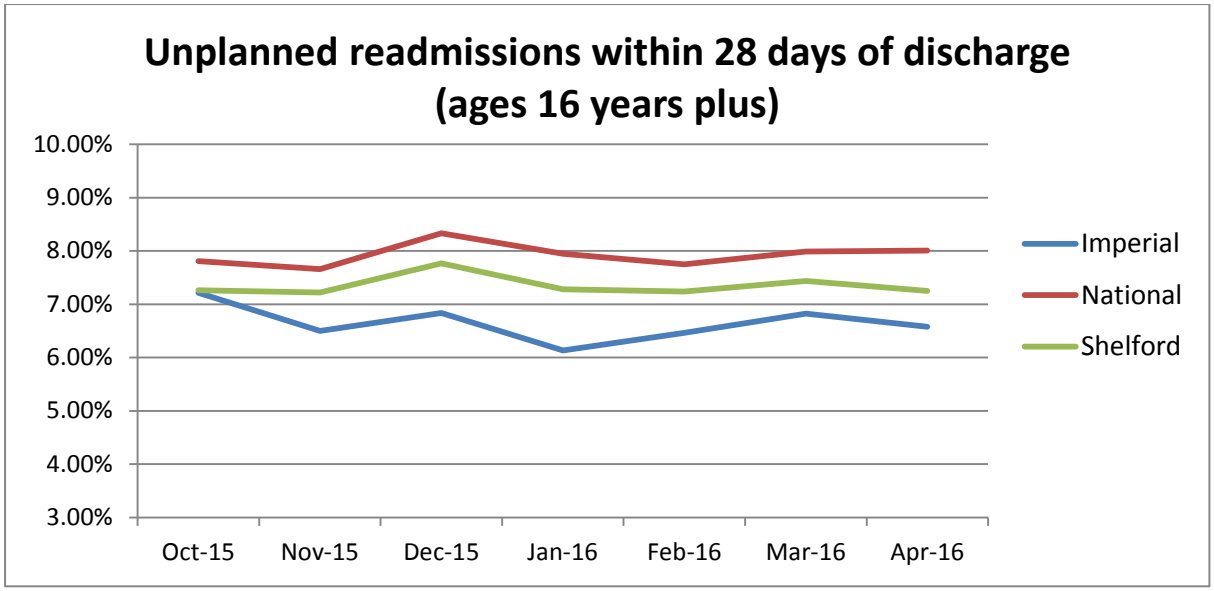


Figure 21 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – April 2016

1.2.7 Effective: Outpatient appointments checked in and checked out

When patients attend for their outpatient appointment they should be checked-in on the Trust system (CERNER) and then checked-out after their appointment so that it is clear what is going to happen next. If these steps are not done the Trust waiting list performance may be affected and patients may also not be moved on promptly to the next stage in treatment.

A new Trust-wide target has been introduced for all outpatient appointments to be checked-in within 1 week of the clinic date after which time they are flagged for action with service leads. This includes a newly agreed escalation process for areas not showing improvement. A similar approach to reducing appointments not checked out is being adopted.

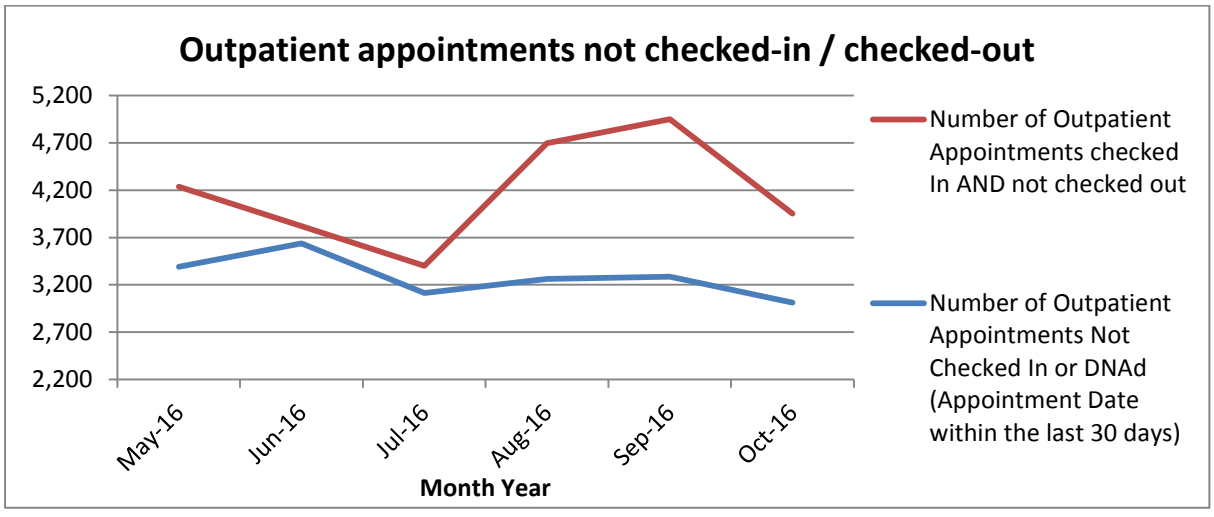


Figure 22 – Number of outpatient appointments not checked-in / checked-out for the period May 2016 – October 2016

1.3 Caring

1.3.1 Caring: Friends and Family Test

The Accident and Emergency response rates remain below target. Options to utilise a similar approach to that employed recently in outpatients is being explored as this has been very successful in terms of increasing the numbers of patients completing the FFT survey.

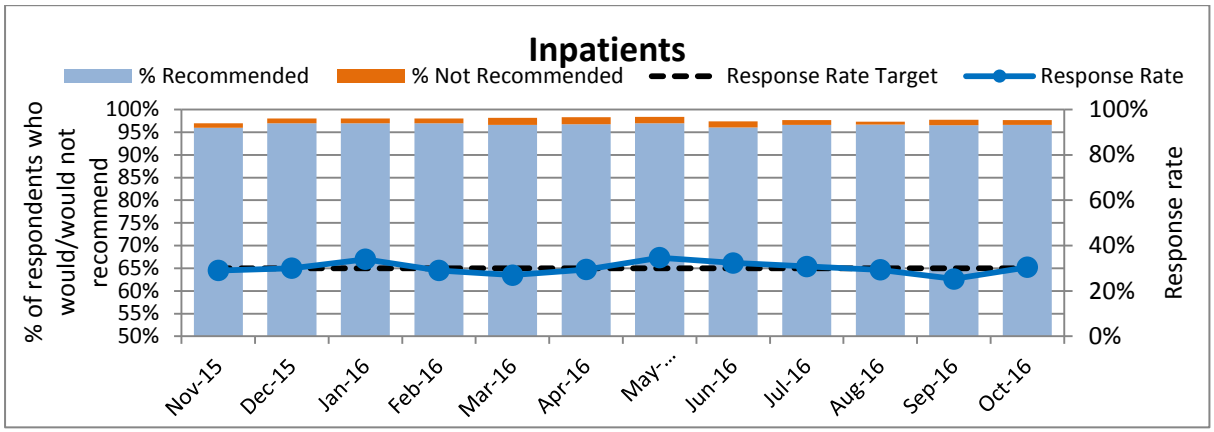


Figure 23 - Friends and Family (Inpatients) for the period November 2015 – October 2016

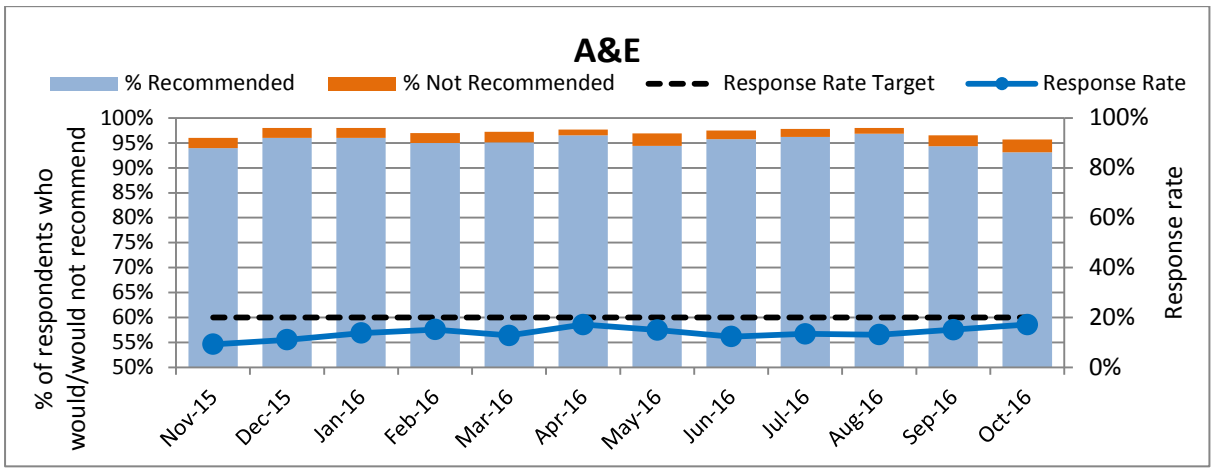


Figure 24 - Friends and Family (Accident and Emergency) for the period November 2015 – October 2016

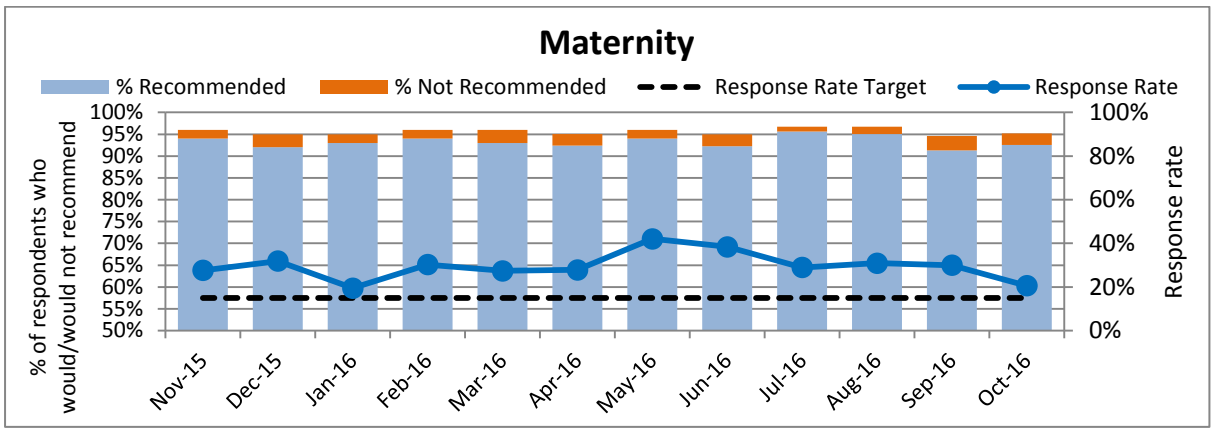


Figure 25 - Friends and Family (Maternity) for the period November 2015 – October 2016

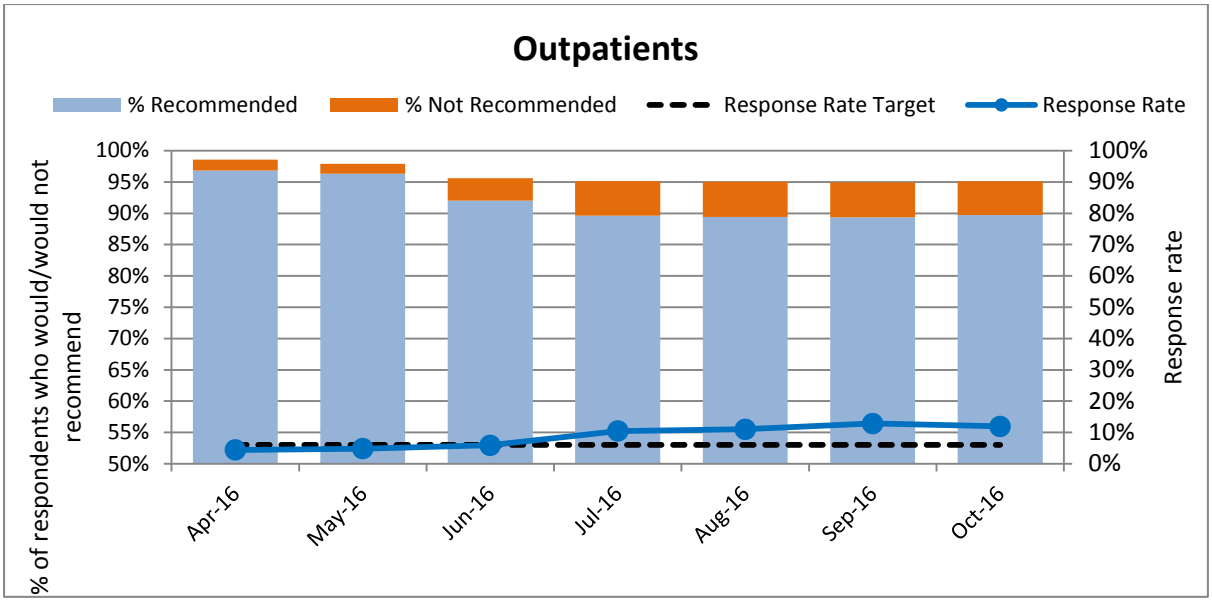


Figure 26 - Friends and Family (Outpatients) for the period April 2016 – October 2016

1.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

In October 2016, 71.72 per cent of patients who left the hospital as part of the non-emergency patient transport scheme left within 120 minutes of their requested pick up time (outward discharges and transfers), against a target of 98 per cent.

One of the main drivers for current performance is compressed demand for the transport service between 1600 and 1800 hrs. The Trust is drafting proposals to spread planned discharges across the day. This will help to reduce transport waiting times, improving performance and patient experience. Other initiatives are being put in place with our service provider to optimise the vehicle fleet utilisation.

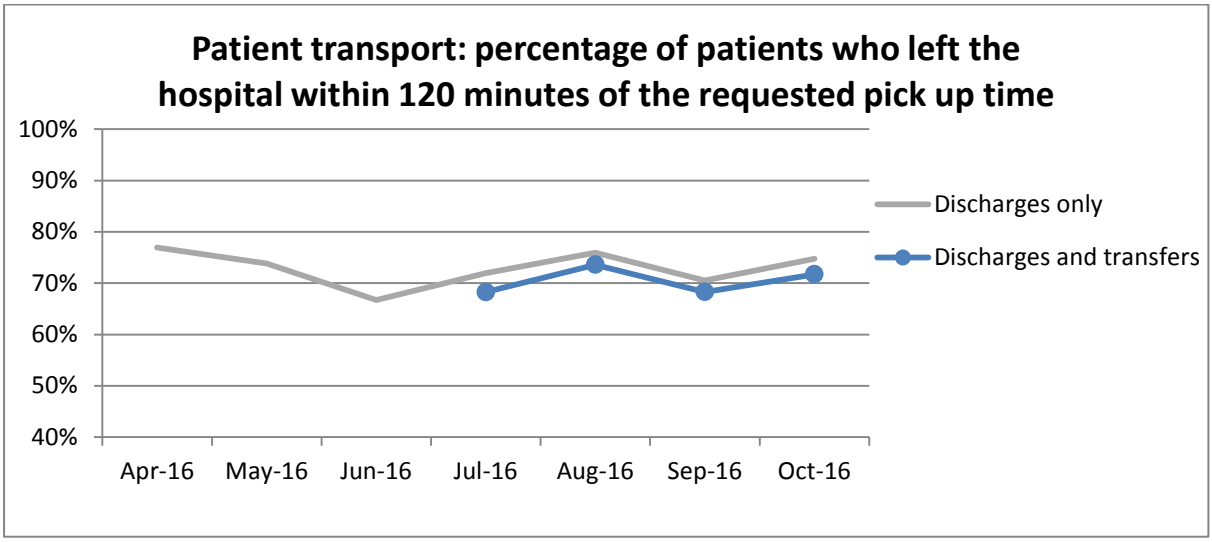


Figure 27 - Percentage of patients who left the hospital (discharges and transfers) as part of the patient transport scheme within 120 minutes of their requested pick up time between April 2016 and October 2016 ***as of July 16 transfers are measured within this indicator*

1.4 Well-Led

1.4.1 Well-Led: Vacancy rate

All Roles

At the end of October 2016, the Trust employed 9,753 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions and Research & Development areas.

The contractual vacancy rate for all roles was 10.27 per cent against the target of 10 per cent (the September performance was 10.21 per cent). During the month there were a total of 294 WTE joiners and 208 WTE leavers across all staffing groups. The Trust's voluntary turnover rate (rolling 12 month position) returned to normal levels of 10.40 per cent following the expected seasonal uplift reported in September of 10.59 per cent.

Actions being taken to support reduction in vacancies across the Trust include:

- Bespoke campaigns for Radiographers, Imaging, Cardiac Services, NICU and Paediatrics
- Open Days booked for 2017
- An assessment and selection tool to help consistent decision-making to support retention and engagement – to be available from January 2017 onwards.

There were 370 WTE candidates waiting to join the Trust across all occupational groups.

Bands 2 - 6 Nursing & Midwifery on Wards

At end of October 2016, the contractual vacancy rate for band 2-6 Nursing & Midwifery ward roles was 15.74 per cent with 378 WTE vacancies; small reduction from the September position of 387 WTE vacancies. Turnover for this staffing group is at 18 per cent with 90 WTE candidates waiting to join the Trust.

Actions being taken to support reduction in vacancies include:

- Second phase of the new Capital Nurse Rotation Foundation programme, in partnership with Health Education England, will start in the new year
- The assessment approach for Healthcare Assisstant recruitment will be changed in November to do testing on online. This will improve the recruitment process.
- An attraction plan developed for theatres including: over-recruiting, changing the mix of Band 5 and 6s, and focused agency recruitment. The vacancy rate is coming down as a result of this intervention.
- Student Nurse Recruitment has launched for February in-take. We are attending events at a number of Universities and advertising free of charge on their news boards and we will run a series of adverts to attract students from a variety of Universities

- The new internal Band 5 transfer process has commenced; Additional advertising is about to be launched

Across London, for all Nursing & Midwifery roles, the vacancy rate averages at 15 per cent, whilst for the Trust, it is currently at 13.06 per cent; reflective of successful and focused recruitment campaigns.

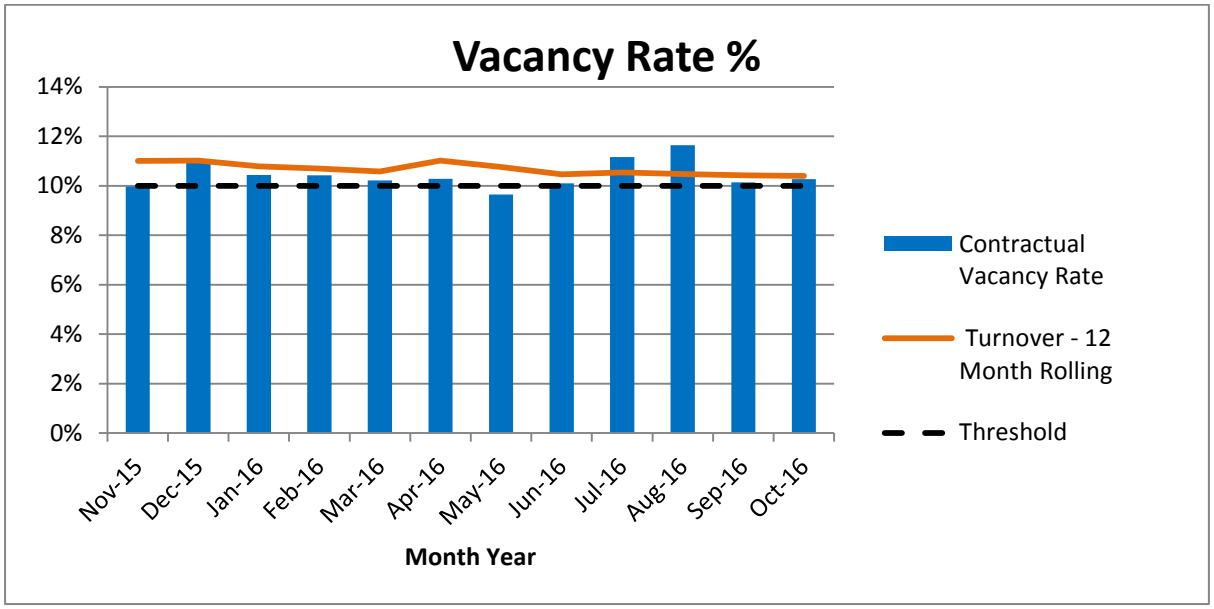


Figure 28 - Vacancy rates for the period November 2015 – October 2016

1.4.2 Well-Led: Sickness absence rate

In October 2016 the recorded sickness absence was 3.13 per cent, against the annual target of 3.10 per cent. The rolling 12 month performance was of 3.06. This is lower than the performance at October 2015 where it was 3.30 per cent.

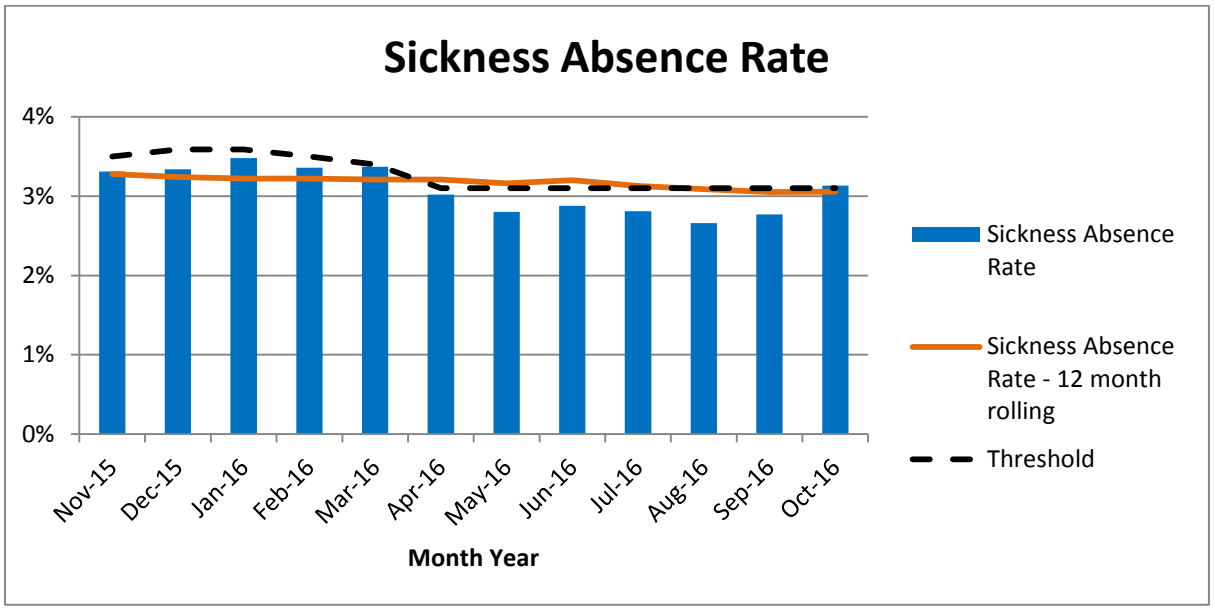


Figure 29 - Sickness absence rates for the period November 2015 – October 2016

1.4.3 Well-Led: Performance development reviews

For the 2016/17 financial year the trust achieved an 86 per cent compliance rate for completed Performance Development Reviews (PDR) for our non-medical staff. The target was for 95 per cent completion by September 2016. The new PDR cycle will begin on 1st April 2017.

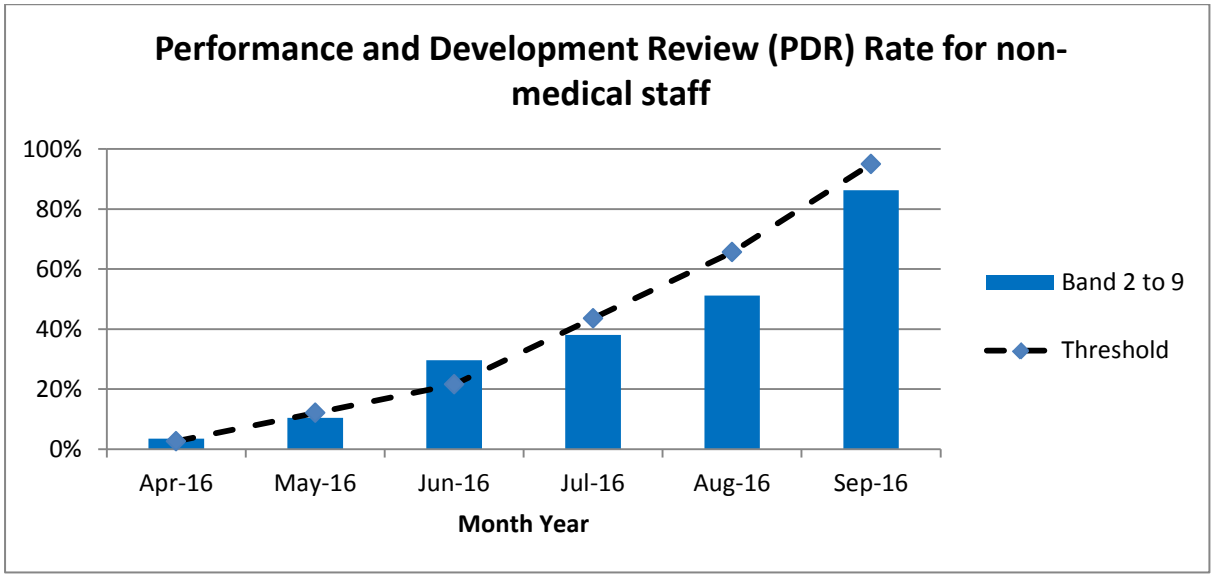


Figure 30 - Band 2 - 9 Performance development review completion rates for the period April 2016 to September 2016

1.4.4 Well-Led: Doctor Appraisal Rate

Overall doctors' appraisal rates have increased slightly this month to 83.3 per cent. As per Trust policy, review meetings are being arranged with doctors whose appraisals are overdue by 3 months to improve compliance.

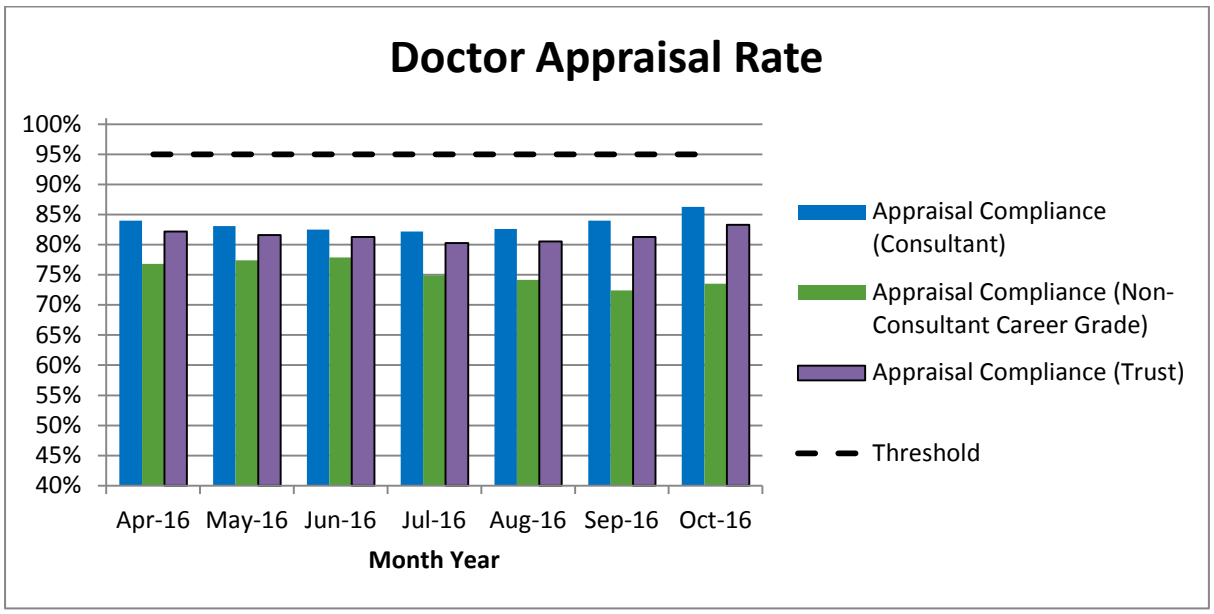


Figure 31 - Doctor Appraisal Rates for the period April 2016 to October 2016

1.4.5 Well-Led: General Medical Council - National Training Survey Actions

Health Education North West London quality visit

There remain 24 actions open from the Health Education North West London quality visit. The next action plan submission will occur in November 2016.

2015/16 General Medical Council National Training Survey

The results of the GMC NTS survey 2015/16 were published in July and show a significant improvement, with 54 green flags compared to 20 last year and 25 red flags (where we are shown to be a significant national outlier), compared to 50 last year.

An action plan in response to the red flags was submitted to Health Education England in October 2016, consisting of 66 actions. The next update is due on 31 December. The numbers of open and closed actions will be monitored through this report going forward.

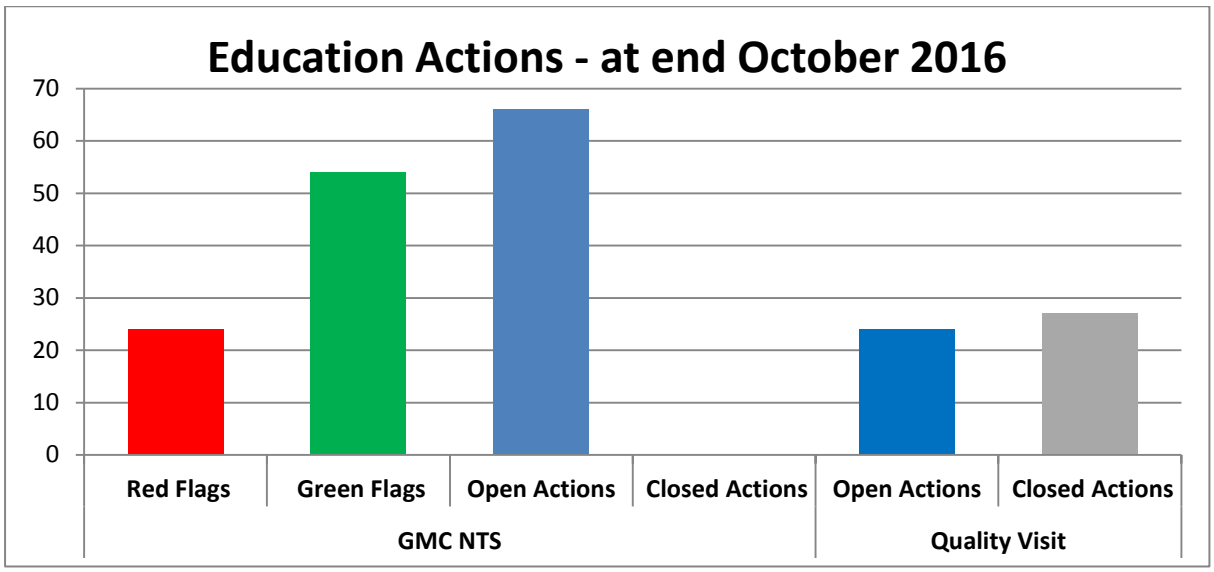


Figure 32 – General Medical Council - National Training Survey action tracker, updated at end October 2016

1.4.6 Well Led: Estates – maintenance tasks completed on time

In October 2016, 62.52 per cent of maintenance tasks were completed within the allocated response time against a target of 98 per cent.

The Trust's facilities management (Hard-FM) contract was outsourced to a new service provider which commenced on 1 April 2016. Overall the volume of calls to the maintenance helpdesk has remained fairly constant and is in line with pre-April 2016 figures. Delays with our service supplier accessing the Trust's maintenance management system have now been addressed, allowing full implementation of standard operating processes. As the contract is beginning to 'bed-in' a steady improvement in reactive repair maintenance performance is expected throughout the remainder of the 2016/17 financial year.

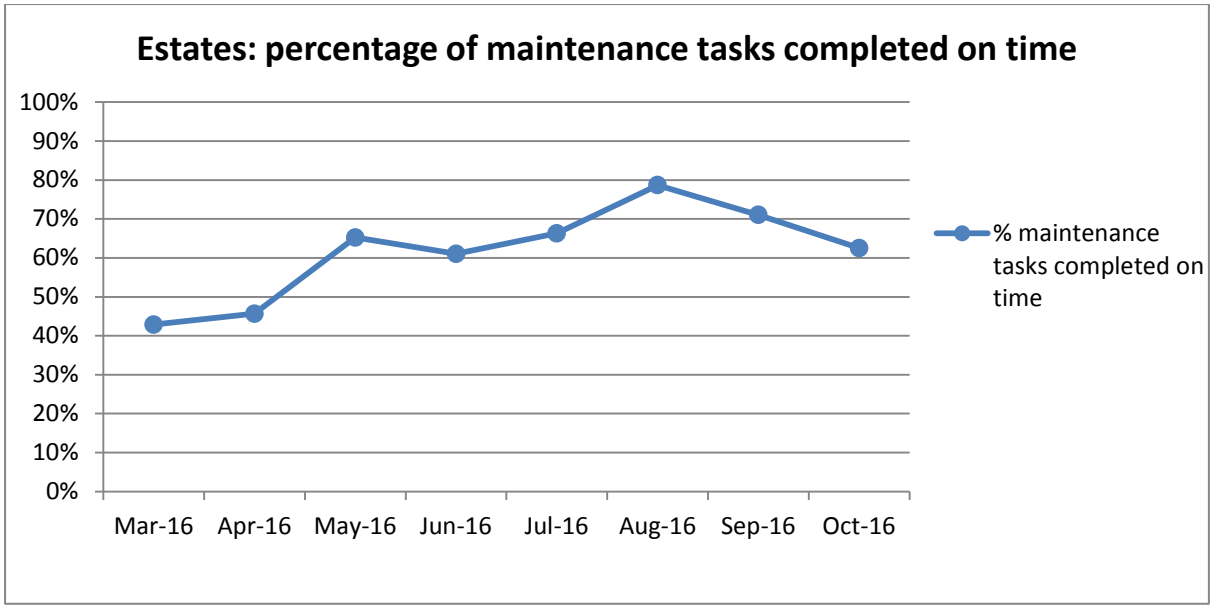


Figure 33 – Estates: percentage of maintenance tasks completed on time for the period March 2016 – October 2016

1.5 Responsive

1.5.3 Responsive: Consultant-led Referral to Treatment waiting times

Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. The performance for October 2016 was 83.40 per cent of patients on an incomplete pathway waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92 per cent (September performance was 81.63 per cent).

At the end of October 2016, 10,624 patients were waiting over 18 weeks (September performance was 10,764 patients).

The Trust Waiting List Improvement Programme (established in July 2016) oversees essential improvements in response to the RTT challenges. The project also oversees the management of the existing clinical review process which provides assurance that patients who wait over 52 weeks are not coming to significant harm. System-wide governance arrangements have been established with our commissioners and the Trust is receiving on-going support from the NHS Elective Intensive Care Team.

The Trust has submitted projections of our future performance alongside our application for Sustainability and Transformation funding. These projections will be updated as more information becomes available from the clean-up of the waiting list data which is being undertaken by the Waiting List Improvement Programme and from the specialty plans to increase capacity to address the underlying issues.

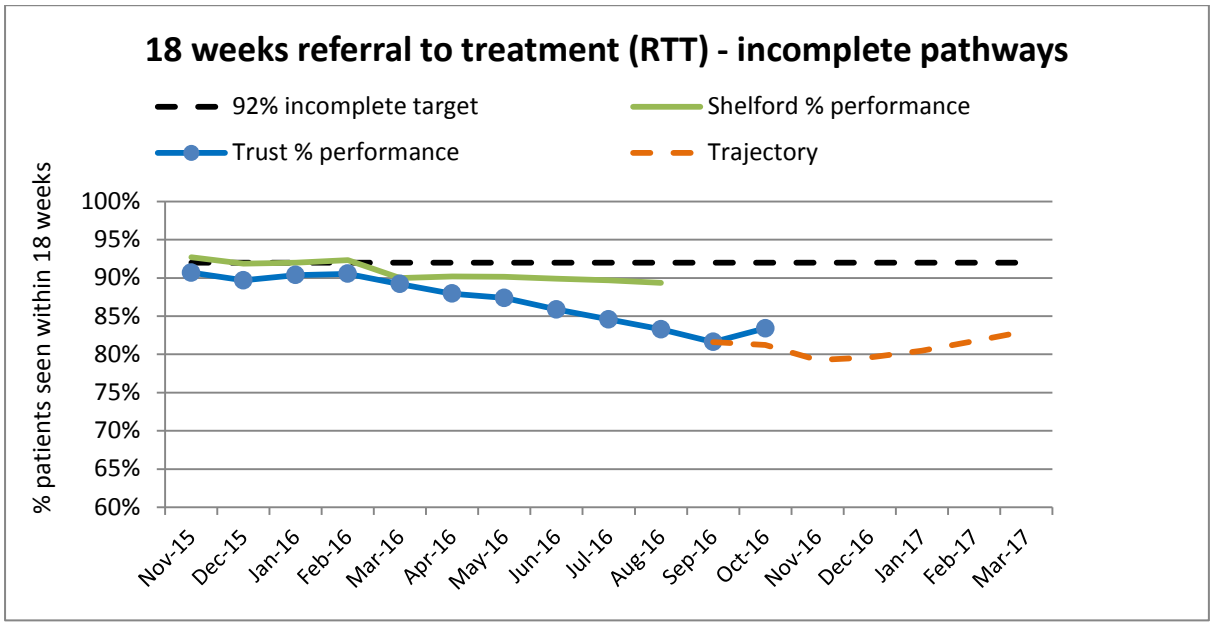


Figure 34 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period November 2015 – October 2016

52 weeks

The clean-up of the inpatient waiting lists through the improvement programme continued in October and is now largely complete. The impact is that there are a large number of patients whom we had not been tracking consistently in specific specialities because RTT rules were applied incorrectly at an earlier stage of the patient's treatment pathway. The numbers of those who are waiting over 52 weeks in Orthopaedics is particularly high.

In total at the end of October 2016, there were 475 patients who had waited over 52 weeks for their treatment since referral from their GP (including 17 patients on gender reassignment pathways). Over 400 patients were identified as part of the data clean-up exercise (242 patients in Orthopaedics, 85 patients in Plastics and 73 patients in ENT). This cohort of long waiters has now been reinstated onto the active RTT waiting list and patients are being contacted to agree a treatment date.

The position for end November is expected to be similar. Some patients will be added to the patient tracking list from continuing audits while a number of the over 52 week waiters reported for October will receive their treatment in November. This includes using outsourcing arrangements in some specialties, where the independent sector can provide capacity for the specific procedures required.

Of the 475 patients reported as waiting over 52 weeks at end October:

- **37** patients were previously reported as waiting over 52 weeks at end of September (incuding data clean-up). Cinical reviews and treatment plans are now in place. In many cases the patient continued to be waiting because they did not wish to have their delayed surgical operation straight away.
- **385** patients are patients identified as part of the data clean-up who have been re-instated onto the RTT waiting list.
- **35** patients were new breaches for whom we had been reviewing regularly, but whose treatment took longer than it should have done because of capacity problems or other reasons.
- **1** additional community pathway was identified.

Clinical reviews and treatments plans are being completed on all patients waiting over 52 weeks at end October.

Gender reassignment surgery pathways

- **17** patients on gender reassignment surgery pathways had waited over 52 weeks at end October 2016. These pathways were reported for the first time in June 2016 following agreement with NHS England which commissions the service from the Trust. The Trust is the only NHS provider of male to female gender reassignment surgery in the country. This backlog is steadily reducing in line with the agreed plan.

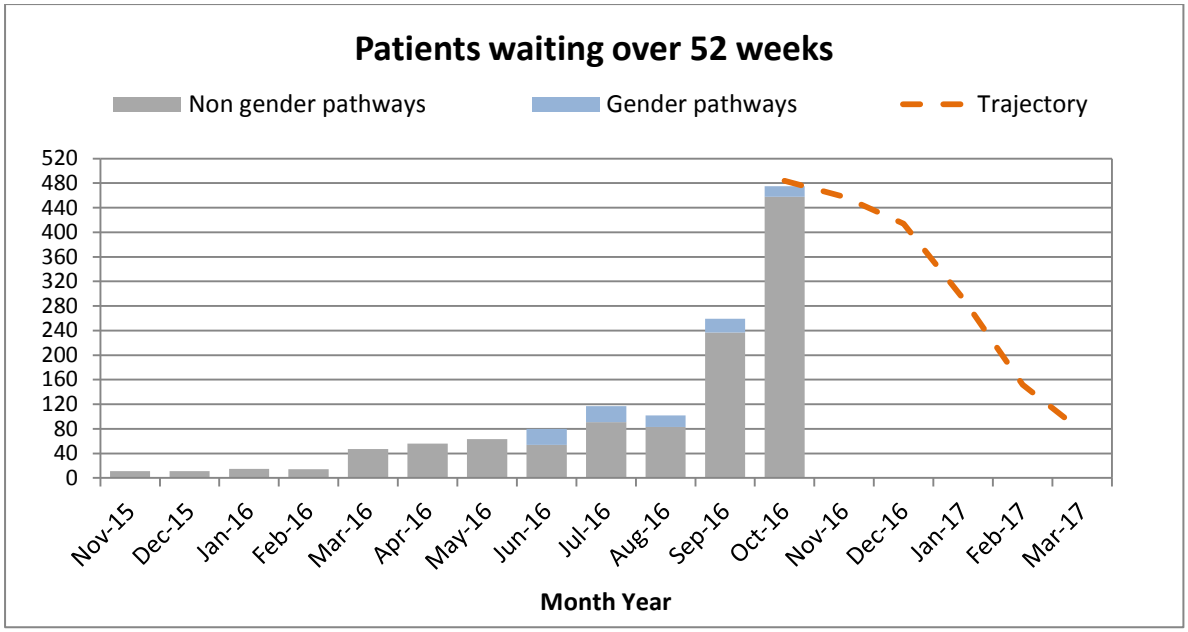


Figure 35 - Number of patients waiting over 52 weeks split by gender pathways and non-gender pathways, for the period November 2015 – October 2016

1.5.4 Responsive: Cancer

In November 2016, performance is reported for Cancer Waiting Times standards for September 2016. In September, the Trust achieved five of the eight national standards. The Trust underperformed against the two-week wait from GP referral to first outpatient appointment, the 62-day wait for GP referral to treatment and the 62-day screening standards.

1. Performance against the two week wait standard has been recovered in October. The CCG has asked that Trusts work to reduce median waits for first outpatient appointments by one day over the next three months. The Trust Corporate Cancer Service will work with the outpatients team and cancer-treating services to deliver this in the new year.
2. Underperformance against the 62-day screening standard was the result of two capacity related breaches within the breast service. A new weekly meeting has been established within the SCC division to support the prioritisation of surgical work in the context of the Cancer Waiting Times and Referral to Treatment recovery plans, which will improve service responsiveness to escalation of capacity issues. The Trust Corporate Cancer Service has also agreed to review the management of internal screening pathways with the Trust lead for women's cancers.
3. The main contributing factor to underperformance against the 62-day GP referral to treatment standard was delays on shared pathways originating from other NWL Trusts. The Trust has agreed a new performance trajectory against the standard with the CCG and NHS Improvement, shown below. The expectation is that internal performance (i.e. with all shared activity excluded) remains compliant

against the 85 per cent operational standard, as was achieved in September. The Trust is expected to deliver internal improvements to urology and colorectal diagnostic pathways within Quarter 3, and work is on track to achieve this. Other NWL trusts have committed to the resolution of delays prior to referral to ICHT within Quarter 3. If this is delivered, the Trust is expected to be compliant with the standard from January 2017. However, the CCG and NHSI understand that aggregate underperformance is likely to continue until the referring sites have addressed their internal pathway issues. ICHT have committed to supporting local sites with the development and delivery of their plans.

From January 2017 performance reporting against the new national breach reallocation policy will be formally rolled out. This is expected to benefit ICHT's reported monthly position against the 62-day GP referral to treatment standard and will support the monitoring of performance improvements on shared treatment pathways.

Indicator	Standard	Quarter 2	Sep-16
Two week from GP referral to 1st outpatient – all urgent referrals (%)	93.0%	92.4%	91.2%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.3%	93.6%
31 day wait from diagnosis to first treatment (%)	96.0%	96.7%	96.1%
31 day second or subsequent treatment (drug treatments) (%)	98.0%	100.0%	100.0%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	98.2%	95.6%
31 day second or subsequent treatment (surgery) (%)	94.0%	97.5%	95.7%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	80.1%	77.5%
62 day urgent GP referral to treatment from screening (%)	90.0%	87.7%	86.0%

Table 1 - Performance against national cancer standards for Quarter 2 and September 2016

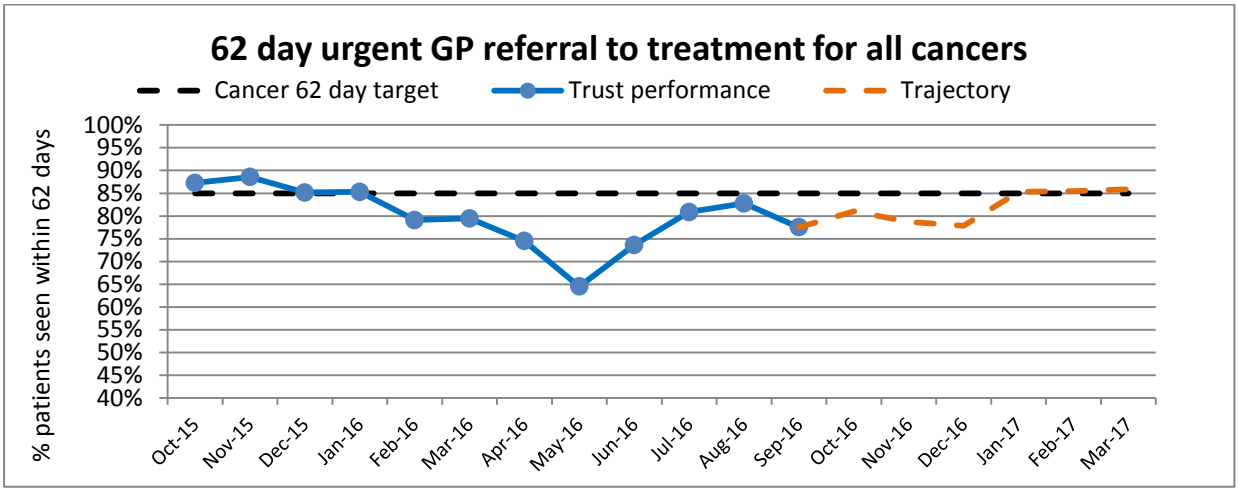


Figure 36 – Cancer 62 day GP referral to treatment performance for the period October 2015 – September 2016

1.5.5 Responsive: Elective operations cancelled on the day for non-clinical reasons

The cancellation rate for September was 0.6 per cent which met the target threshold of 0.8 per cent. The 28-day rebooking breach rate remained above the threshold of 5 per cent. Validation of October cancellations is not yet complete.

A Trust-wide action plan has been developed which focusses on improving communication arrangements to minimise cancellations made on the day, greater visibility of high priority patients and improved escalation of 28 day rebooking to ensure earlier management intervention.

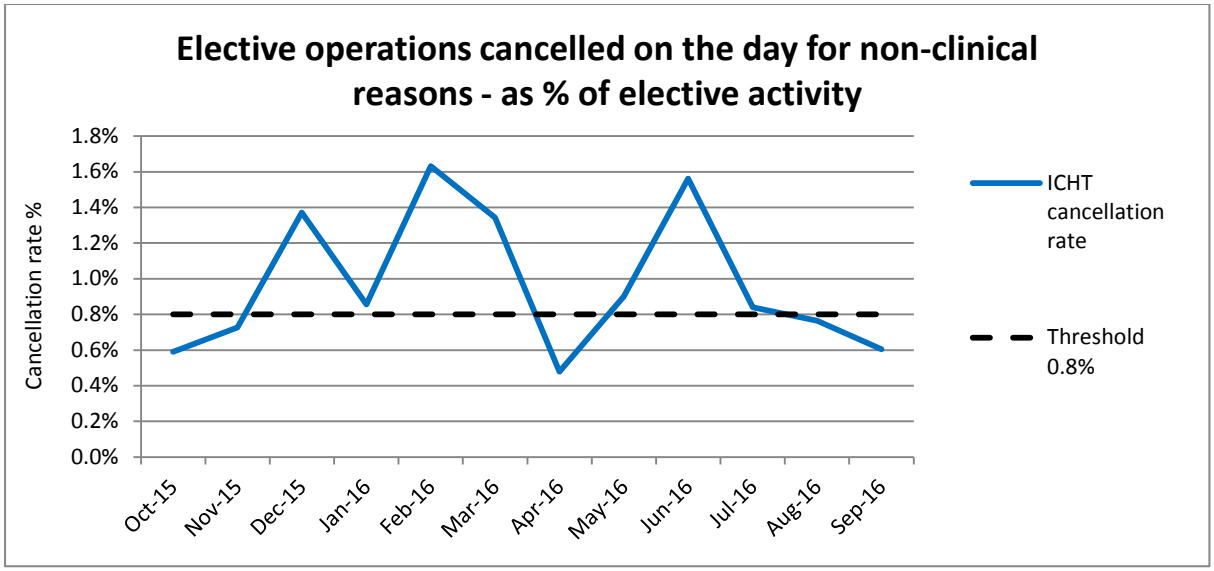


Figure 37 - Elective operations cancelled at the last minute for non-clinical reasons as a % of elective admissions for the period October 2015 – September 2016

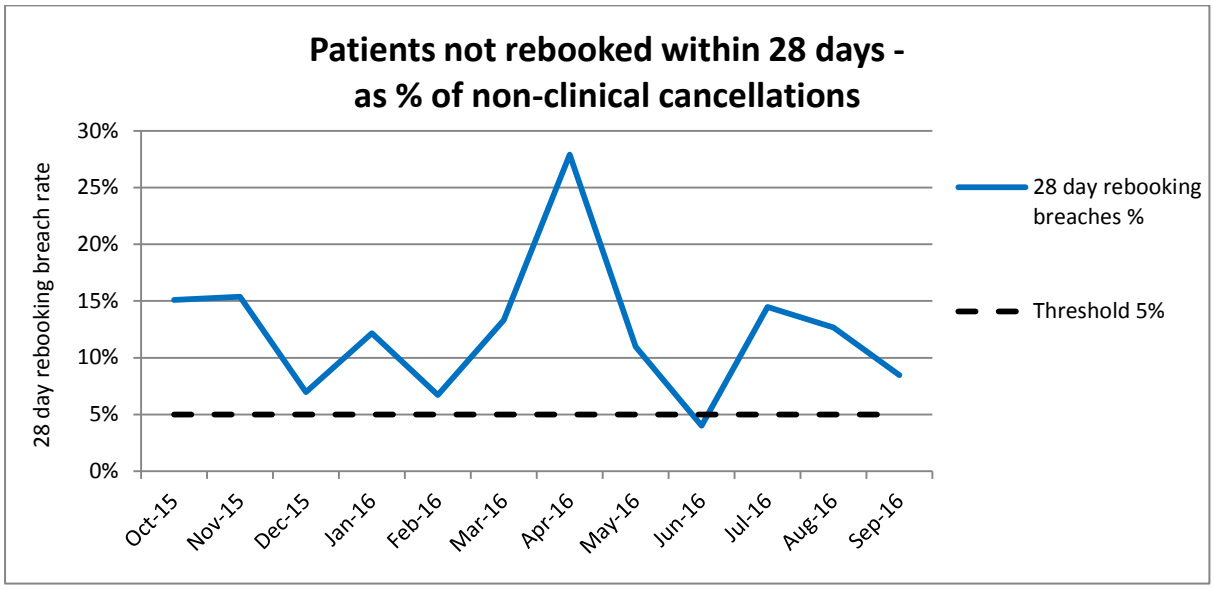


Figure 38 - Patients not treated within 28 days of their cancellation as a % of cancellations for the period October 2015 – September 2016

1.5.6 Responsive: Accident and Emergency

In October 2016, performance against the four hour access standard for patients attending Accident and Emergency was 87.03 per cent, which met the revised performance trajectory target 86.65 per cent for the month.

The drivers of current levels of performance continue to be:

- Increasing demand, especially at CXH
- Increasing acuity (much of the increase in demand is through ambulance arrivals)
- Delays and difficulties with the pathway from the Urgent Care Centre to the Emergency Department at SMH
- Crowding has been a particular problem and the recently approved Full Capacity Protocol was instigated on two occasions during October. The Site Operations Team coordinated a successful response and a full debrief following both incidents.

Actions underway to improve performance during November are:

- A second “Playing our Part” week
- The Ambulatory Emergency Care service to move to 7 day working at CXH (this is already in place at SMH)

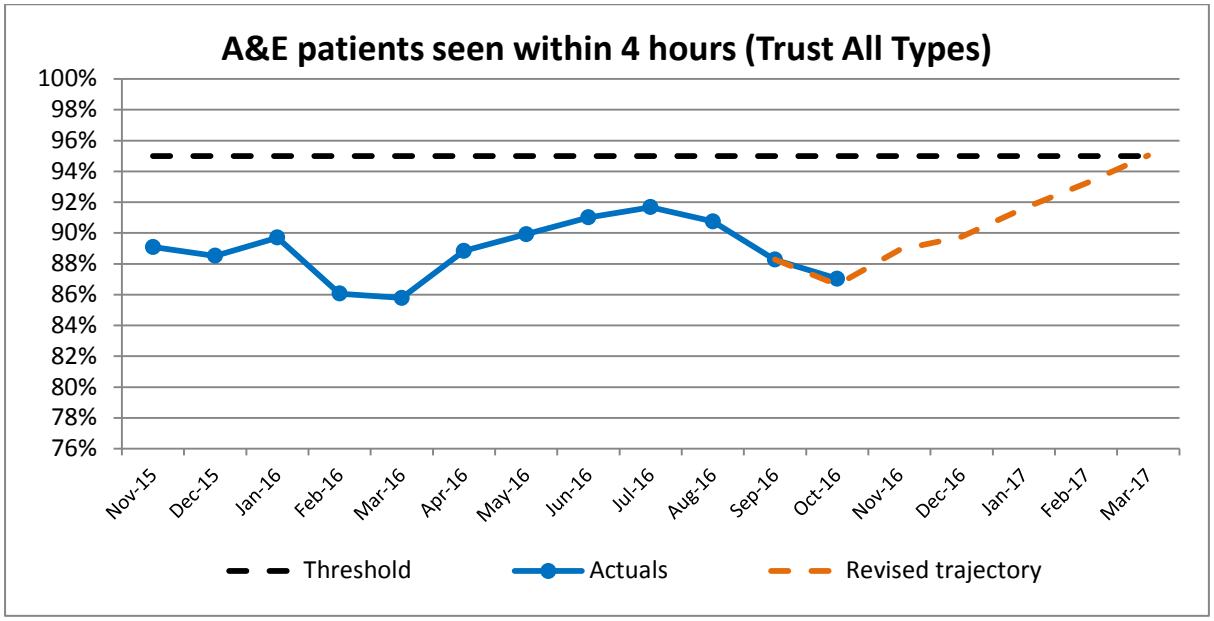


Figure 39 – A&E Maximum waiting times 4 hours (Trust All Types) for the period November 2015 – October 2016

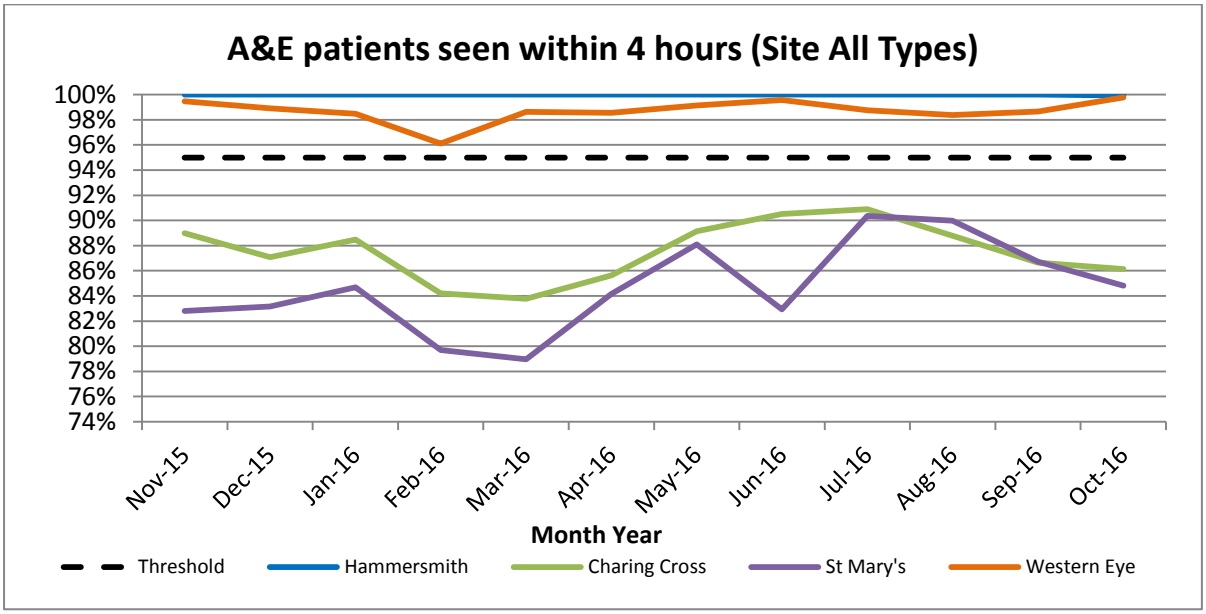


Figure 40 – A&E Maximum waiting times (Site All Types) 4 hours for the period November 2015 – October 2016

1.5.7 Responsive: Diagnostics

In October 2016, the Trust met the monthly 6 week diagnostic waiting time standard with 0.24 per cent of patients waiting over six weeks against a tolerance of 1 per cent. Work continues to strengthen diagnostic reporting and planning as per the Trust diagnostic action plan.

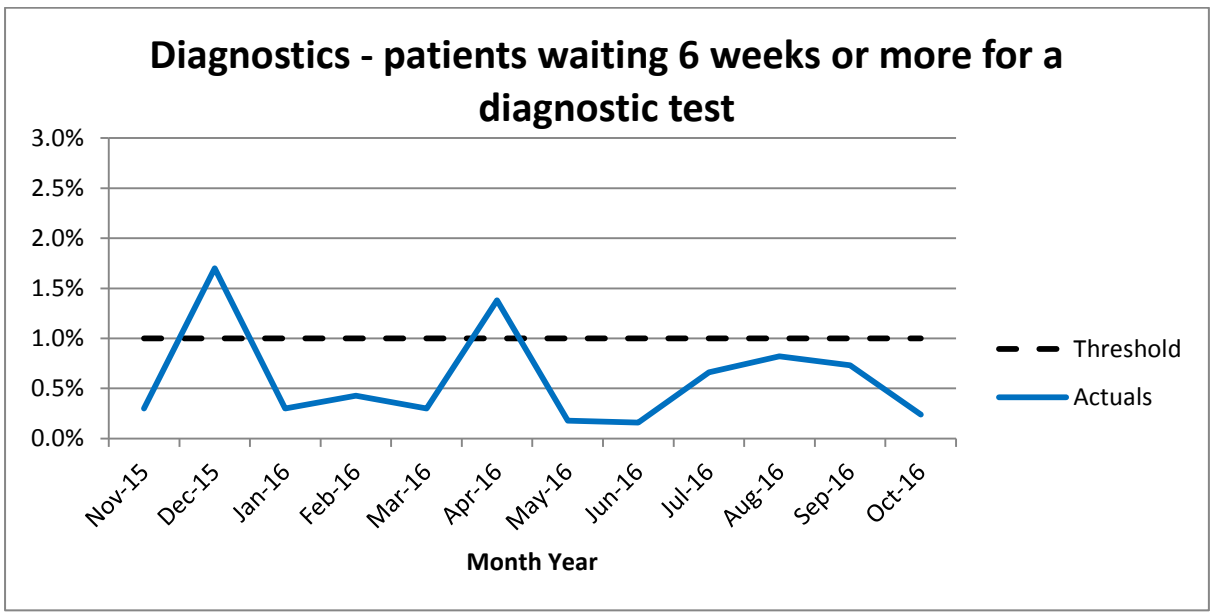


Figure 41 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period November 2015 – October 2016

1.5.8 Responsive: Patient attendance rates at outpatient appointments

In October, the aggregate DNA (first and follow up) performance was 11.3 per cent which equates to a total of 9,750 appointments in the month and 464 DNAs per working day. This is an improvement on September performance of 11.5 per cent (9,952 appointments).

A new process has been introduced in Maternity services to identify women who have given birth and then prospectively cancel future antenatal appointments that have been booked. The number of DNAs for midwife episodes has reduced by 160 (15 per cent) in the last month.

Any impact related to the introduction of 7-day voice reminders for centrally booked services has not yet been quantified. This is a priority action within the business intelligence team.

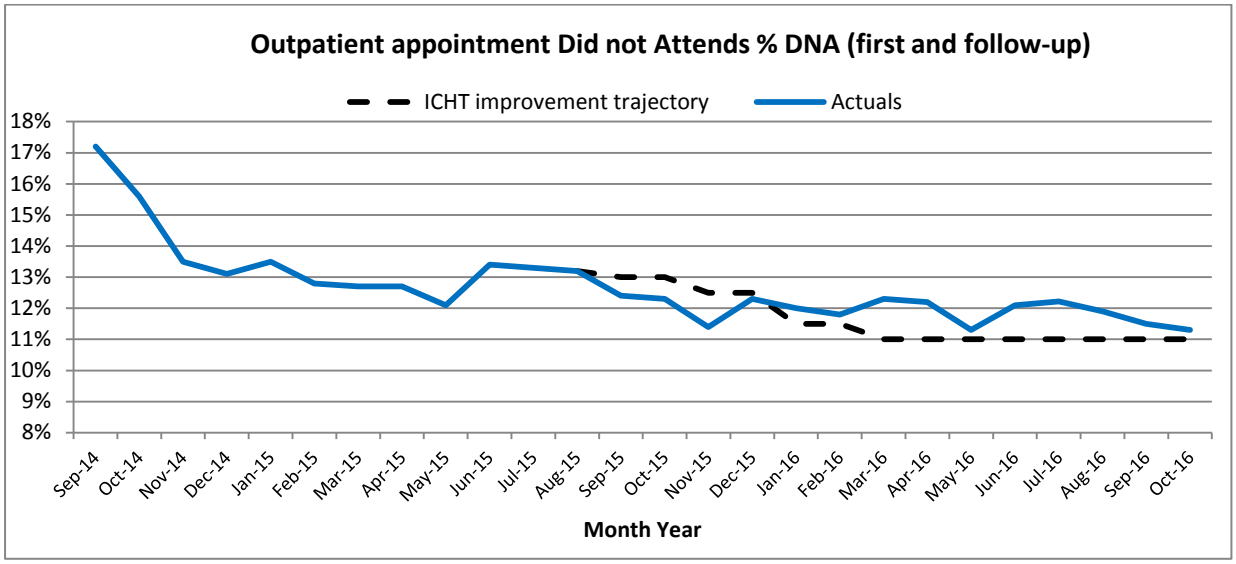


Figure 42 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period September 2014 – October 2016

1.5.9 Responsive: Outpatient appointments cancelled by the Trust

In October, 12.9 per cent of outpatient appointments (15,341) were cancelled by the Trust with 8.0 per cent (9,562) of these cancelled at less than 6 weeks' notice. This equates to 731 appointments per working day, of which 455 appointments are at short notice. While this is a slight improvement on the September position of 13 per cent, the percentage at short notice has gone up compared to 7.7 per cent last month.

PricewaterhouseCoopers are currently supporting the outpatient directorate team to analyse the volume of hospital initiated cancellations for outpatients (HICs) and the reason codes given at less than 6 weeks' notice, so as to inform specialty specific improvement plans. They are also liaising with individual business managers to find out how consultant leave is currently managed in their area.

The central booking office has agreed to enforce the HICs policy and reject any short notice cancellation requests provided without the correct authorisation of a general manager or clinical director.

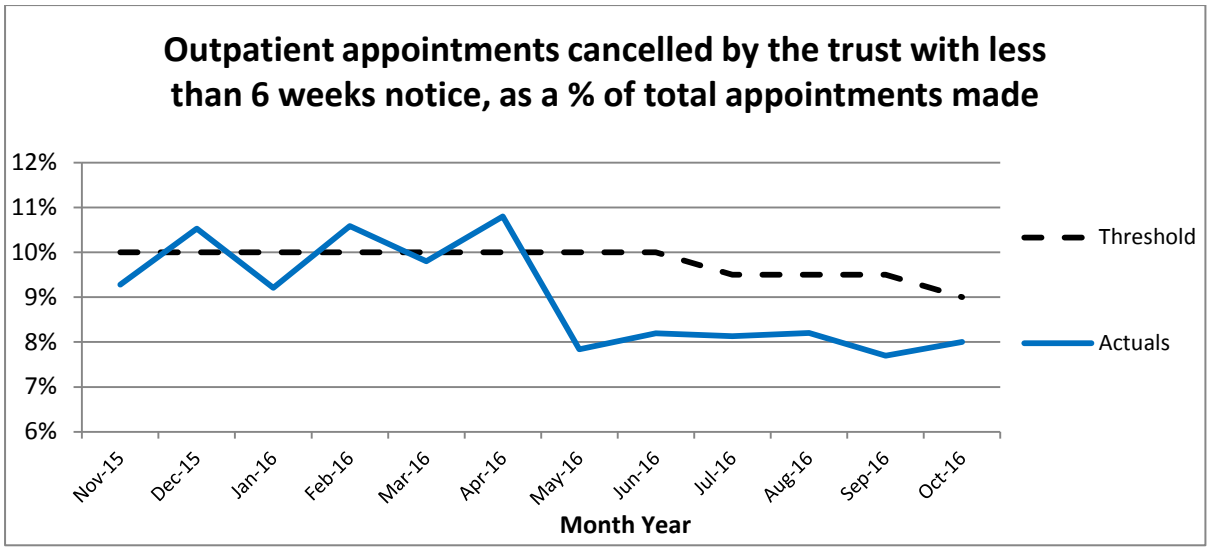


Figure 43 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period November 2015 – October 2016

1.5.10 Responsive: Outpatient appointments made within 5 days of receipt

The Trust's quality strategy target is for 95 per cent of routine outpatient appointments to be made within 5 working days of receipt of referral. In October, 76.4 per cent of routine appointments were made within 5 days compared to 70.7 per cent in September.

The project team leading the implementation of the Patient Service Centre has successfully introduced new ways of working to reduce the time taken to register a referral following receipt in to the Trust. In October, just over 75 per cent were registered within 2 working days compared to just 58 per cent a year ago.

Other initiatives being progressed include the introduction of an electronic vetting (e-vetting) solution providing clinicians with instant access to vet a referral the moment it has been registered and uploaded to the clinical document library (CDL). The e-vetting solution is being piloted in December with clinicians alongside an escalation process to highlight vetting delays.

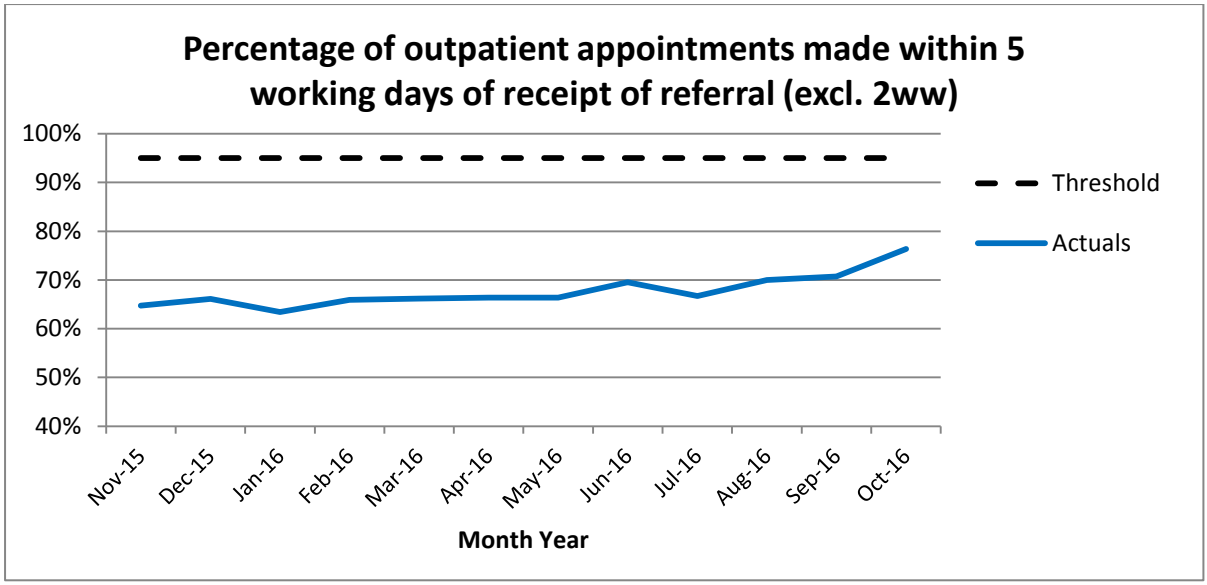


Figure 44 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period November 2015 – October 2016

1.5.11 Responsive: Access to antenatal care – booking appointment

In October 2016, 96.4 per cent of pregnant women accessing antenatal care services completed their booking appointment by 12 weeks and 6 days (excluding late referrals), meeting the target of 95 per cent or more. The Trust is expected to continue to achieve this access standard during 2016/17.

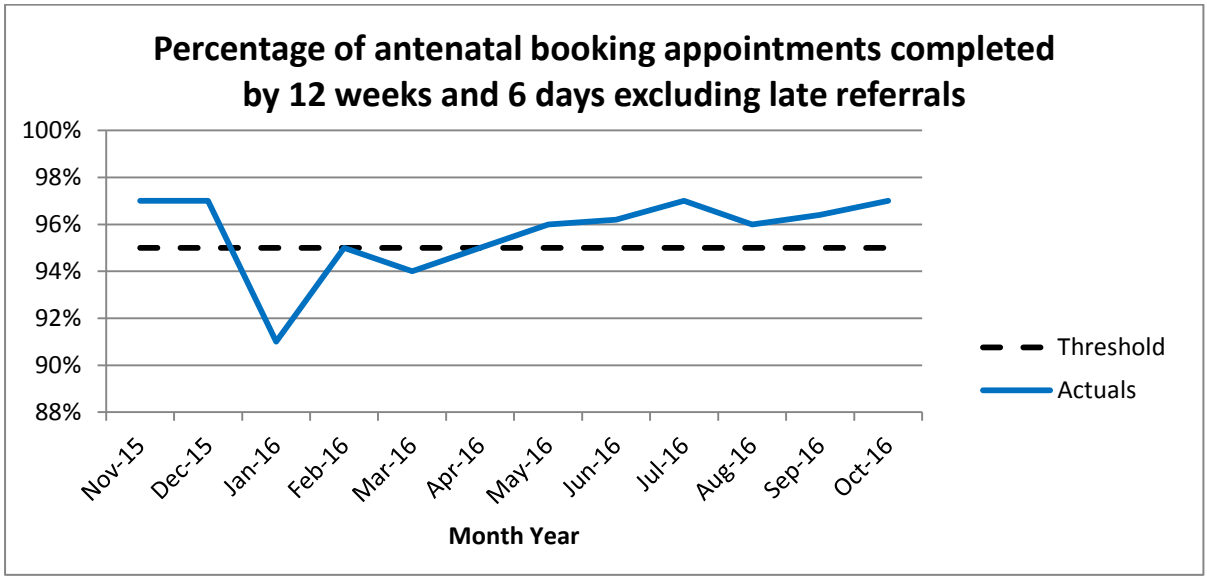


Figure 45 – Percentage of antenatal booking appointments completed by 12 weeks and 6 days excluding late referrals for the period November 2015 – October 2016

1.5.12 Responsive: Complaints

The monthly volume of complaints rose in October but remained below the target threshold. Performance against acknowledgement and response time targets remains good.

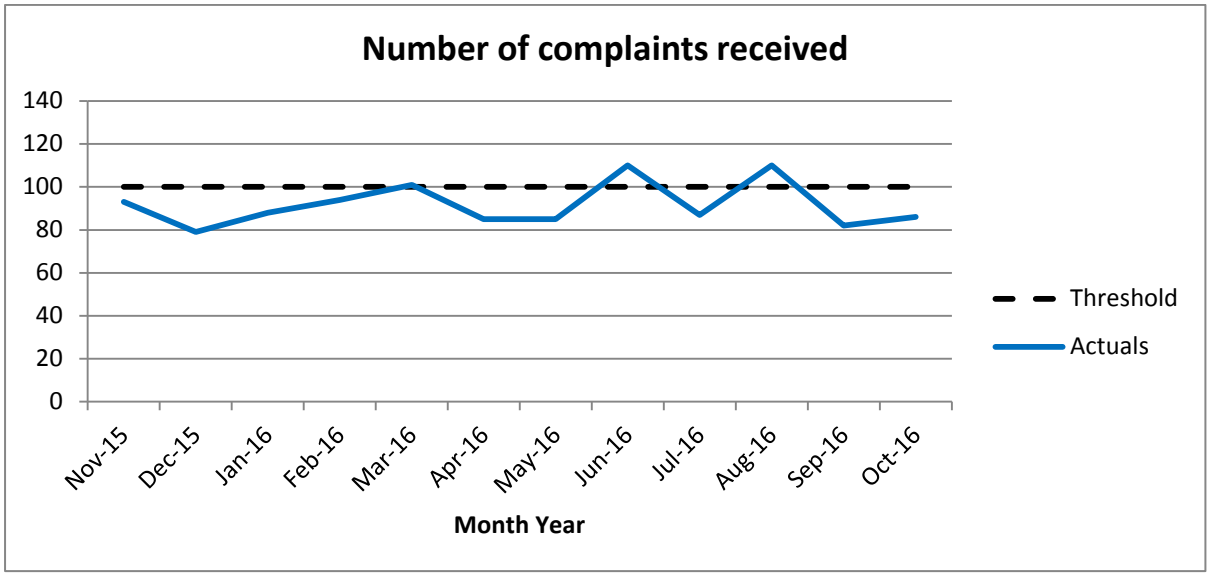


Figure 46 – Number of complaints received for the period November 2015 – October 2016

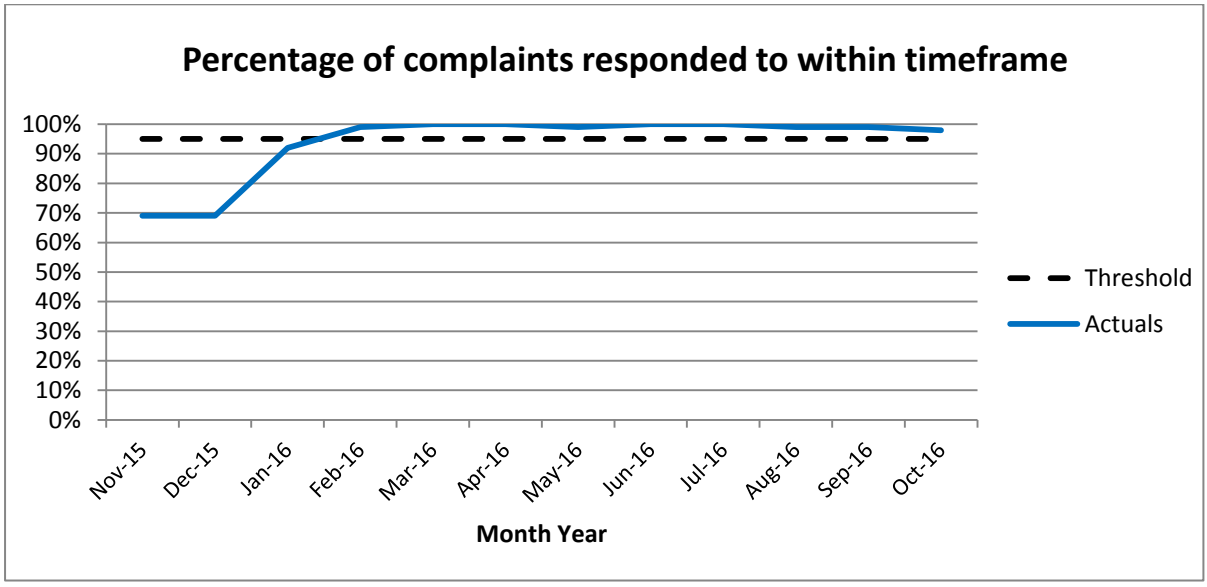


Figure 47 – Response times to complaints for the period November 2015 – October 2016

2. Finance

Please refer to the Monthly Finance Report to Trust Board for the Trust's finance performance.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	30 November 2016

Finance Report for the seven months to end October 2016

Executive summary:

This paper presents the month 7 financial position including the in month and year to date position.

Overall, the Trust met its plan in month and is £0.5m favourable to plan year to date. The plan now reflects our agreed stretch target with NHSI, an £11m increase on our original plan.

Quality impact:

N/A

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

Risks are highlighted in the summary pages

Recommendation(s) to the Committee:

The Board is asked to *note the paper, including the risks and recommended actions*

Trust strategic objectives supported by this paper:

Retain as appropriate:
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Janice Stephens, Deputy CFO Michelle Openibo, Associate Director: Business Partnering	Richard Alexander, CFO	24th November2016

IMPERIAL COLLEGE HEALTHCARE NHS TRUST

FINANCE REPORT – 7 MONTHS ENDED 31st October 2016

1. Introduction

This report provides a brief summary of the Trust's financial results for the 7 months ended 31st October 2016. The Trust Board is asked to note this paper.

2. Summary

During September the Trust agreed a revised control total with NHSI of a deficit of £41m. The Trust is now eligible for Sustainability and Transformation Funding (STF) of £24.1m, which will be given by NHSI if financial and performance criteria are met.

The Trust is reporting a deficit of £28.5m before STF; a favourable variance to plan of £0.47m. Including STF the trust has a deficit of £14.4m. The table below provides a summary of the income and expenditure position.

	In Month			Year To Date (Cumulative)		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	87.96	87.37	(0.58)	603.03	611.16	8.13
Pay	(50.38)	(49.66)	0.73	(349.12)	(344.25)	4.87
Non Pay	(35.00)	(35.33)	(0.33)	(248.00)	(261.21)	(13.21)
Reserves	(0.63)	(0.63)	(0.00)	(6.90)	(6.90)	(0.00)
EBITDA	1.94	1.75	(0.19)	(1.00)	(1.20)	(0.21)
Financing Costs	(2.45)	(2.51)	(0.06)	(19.69)	(24.25)	(4.56)
SURPLUS / (DEFICIT) including donated asset treatment	(0.50)	(0.75)	(0.25)	(20.68)	(25.45)	(4.77)
Donated Asset treatment	(1.62)	(1.37)	0.25	(8.29)	(3.05)	5.24
Impairment of Assets	-	-	-	-	-	
SURPLUS / (DEFICIT)	(2.13)	(2.12)	0.00	(28.97)	(28.50)	0.47
STF Income	2.01	2.01	-	14.06	14.06	-
SURPLUS / (DEFICIT) after STF income	(0.12)	(0.11)	0.00	(14.91)	(14.44)	0.47

Income is above plan by £8.1m year to date, £3.7m of which relates to income for pass through drugs and devices. Pay is favourable reflecting slippage on investments for CIP schemes. Within pay, agency continues to be below last year's spend and below the agency cap. Non Pay is adverse to plan, £13.2m year to date of which £3.7m relates to pass through costs which have offsetting variances in income and much of the balance primarily reflects the costs of delivering the additional activity.

3. Revenue

3.1 NHS Activity and Income

The summary table shows the position by division.

Divisions	Year To Date Activity			Year To Date Income (£m)		
	Plan	Actual	Variance	Plan	Actual	Variance
Total Division of Medicine and Integrated care	452,054	488,034	35,980	141.16	142.47	1.31
Total Division of Surgery, Cancer and Cardiovascular	382,747	377,369	(5,379)	160.61	160.80	0.19
Total Division of Women, Children and Clinical Support	185,850	248,251	62,400	77.78	78.69	0.91
Central Income	-	-	-	75.54	79.96	4.42
Pathology	1,207,671	1,244,423	36,752	7.43	7.54	0.11
Clinical Commissioning Income	2,228,322	2,358,076	129,754	462.52	469.46	6.94

[Note: The Central division reports those revenue streams from NHS commissioners that are not for direct patient care or managed through patient care facilities controlled by the clinical divisions (such as for patient transport); or items that have a 'contra' impact on expenditure.]

Income from elective care is underperforming, mainly in Surgical specialties, however this is somewhat offset by increases in accident and emergency and non elective inpatient care. There have been delays in the implementation of some community schemes which has caused underperformance on plan in this area.

3.2 Private Care income

Private care income has improved against plan since April however in month income was £0.5m behind plan and £0.9m behind plan year to date. Income was low in month as additional income generation schemes are behind plan. Schemes are forecast to be delivering by year end. The income plan for the year is circa £5m higher than the outturn last year.

3.3 Clinical Divisions

The devolved financial position for clinical divisions is set out in the table below.

	In Month			YTD		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	21.42	22.68	1.26	150.85	152.20	1.35
Expenditure	(16.94)	(17.08)	(0.14)	(120.97)	(121.85)	(0.88)
Medicine and Integrated Care	4.48	5.60	1.12	29.89	30.35	0.46
Income	23.15	23.79	0.64	163.07	163.71	0.64
Expenditure	(20.75)	(21.13)	(0.38)	(143.55)	(145.15)	(1.60)
Surgery, Cancer and Cardiovascular	2.40	2.66	0.26	19.52	18.56	(0.96)
Income	12.55	12.93	0.38	86.17	87.09	0.92
Expenditure	(11.91)	(11.69)	0.22	(84.21)	(83.52)	0.69
Women, Children & Clinical Support	0.64	1.24	0.60	1.95	3.57	1.62
Income	3.14	2.41	(0.73)	20.94	19.83	(1.11)
Expenditure	(5.26)	(5.34)	(0.08)	(35.84)	(36.24)	(0.41)
Pathology	(2.12)	(2.93)	(0.81)	(14.90)	(16.41)	(1.52)
Imperial Private Healthcare	1.17	1.15	(0.02)	7.03	7.20	0.17
Total Clinical Division	6.57	7.72	1.15	43.49	43.27	(0.23)

Medicine is £0.5m ahead of plan, mainly due to additional income in specialties such as Neurosciences and Renal. Surgery is £1.0m behind plan driven in the main by slippage on CIP schemes and additional staff costs to cover vacancies. Women, Children and Clinical Support is favourable to plan by £1.6m, this is driven by above plan income performance and underspends particularly on pay. Pathology has been shown separately in preparation for the start of the NWL Pathology venture next year and is underperforming by £1.5m year to date mainly due to under achievement on income contracts and the slower than expected delivery of some savings programmes. Private Health is favourable to plan year to date by £0.17m: whilst income is behind plan, costs are being contained to offset the underperformance.

4. Efficiency programme

£26.5m of CIP efficiencies have been delivered in the first 7 months of the year, adverse to plan by £1.8m. In October the Trust over delivered its monthly target on CIPs by £1.0m, mainly due to additional CIPs formalised in the Medicine and Integrated Care Division. The main driver for underperformance on plan in the Surgery, Cancer and Cardiovascular Division are activity growth schemes that have been slow to start. Medicine and Integrated Care and Women, Children and Clinical Support Divisions both have unidentified CIPs which are the key factor in the year to date underperformance. Pathology underperformance is due to failure of non pay contract savings. The Trust is working with PWC through its Financial Improvement Plan to ensure that new CIP plans are developed and the total Trust CIP plan including stretch is delivered in full.

5. Cash

The cash balance at the end of the month was £28.8m.

6. Conclusion

The Trust is favourable to plan year to date by £0.5m. There are a number of risks, notably delivery of the CIP programme and the size of NHS income over performance which may cause an affordability issue for commissioner. The Executive continues to work internally to reduce costs while safeguarding quality and with the commissioners and NHSI to ensure fair remuneration for activity carried out.

The additional stretch target agreed on CIPs to reach the £41m deficit position is now planned into the Trust budget from November. Clinical Divisions are working with the PSO team to identify and achieve these savings.

The Trust Board is requested to note this report.

Appendix

Statement of Comprehensive Income – 7 months to 31st October 2016

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	69.0	70.0	1.1	473.8	487.4	13.6
Private Patients	4.4	3.9	(0.5)	28.0	27.0	(0.9)
Research & Development & Education	9.0	9.2	0.2	63.2	63.4	0.2
Other	5.6	4.2	(1.4)	38.0	33.4	(4.7)
TOTAL INCOME	**88.0**	**87.4**	**(0.6)**	**603.0**	**611.2**	**8.1**
Expenditure						
Pay - In post	(49.1)	(43.5)	5.7	(340.3)	(303.5)	36.8
Pay - Bank	(0.5)	(3.2)	(2.7)	(4.5)	(22.2)	(17.7)
Pay - Agency	(0.8)	(3.0)	(2.2)	(4.4)	(18.6)	(14.2)
Drugs & Clinical Supplies	(23.3)	(23.5)	(0.2)	(163.8)	(168.7)	(4.9)
General Supplies	(2.8)	(2.9)	(0.1)	(19.8)	(21.0)	(1.1)
Other	(8.9)	(9.0)	(0.1)	(64.4)	(71.6)	(7.2)
TOTAL EXPENDITURE	**(85.4)**	**(85.0)**	**0.4**	**(597.1)**	**(605.5)**	**(8.3)**
Reserves	(0.6)	(0.6)	(0.0)	(6.9)	(6.9)	(0.0)
Earnings Before Interest, Tax, Depreciation & Amortisation	**1.9**	**1.8**	**(0.2)**	**(1.0)**	**(1.2)**	**(0.2)**
Financing Costs	(2.4)	(2.5)	(0.1)	(19.7)	(24.3)	(4.6)
SURPLUS / (DEFICIT) including financing costs	**(0.5)**	**(0.8)**	**(0.2)**	**(20.7)**	**(25.5)**	**(4.8)**
Donated Asset treatment	(1.6)	(1.4)	0.3	(8.3)	(3.0)	5.2
SURPLUS / (DEFICIT) including donated asset treatment	**(2.1)**	**(2.1)**	**0.0**	**(29.0)**	**(28.5)**	**0.5**
Impairment of Assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	**(2.1)**	**(2.1)**	**0.0**	**(29.0)**	**(28.5)**	**0.5**
STF	2.0	2.0	0.0	14.1	14.1	0.0
SURPLUS / (DEFICIT)	**(0.1)**	**(0.1)**	**0.0**	**(14.9)**	**(14.4)**	**0.5**

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

Recruitment of external auditors

Executive summary:

Following the changes to the local external audit arrangements from the Local Audit Accountability Act 2014 (the Act), NHS trusts need to procure and locally appoint their own auditors by December 2016 for the year 2017 to 2018 and subsequent financial years. There are a number of requirements set in legislation which include the role of auditor panels, and that auditors have to be registered through the regulation process to be eligible to audit local public bodies. The duties of the auditors are set out in the Act, together with their compliance with the Code of Audit Practice issued by the NAO.

The Audit, Risk and Governance Committee agreed to act as the Audit Panel and amended it terms of reference to accommodate this. Further to this, and to avoid any perception of conflict of interest, Sir Gerry Acher declared a potential conflict of interest, and stepped down from both chairing the Audit Panel and from voting on the final appointment.

Bids were received from BDO LLP, the incumbents, and Deloitte LLP, the Trust's previous auditors. An evaluation team of Trust senior officers reviewed the bids received and received initial presentations from each of the potential auditors.

The bids were evaluated with the scoring mechanism of 50% quality and 50% cost. The Evaluation Panel recommended that Deloitte LLP was confirmed as preferred bidder.

Papers provided for the Audit Panel advised members of the following:

- Role of the Audit Panel in the procurement process;
- Evaluation team & progress to date;
- Recommendation & evaluation results;
- Next steps to award of contract; and
- Notification of the appointment.

The Audit Panel asked that, should any future external audit procurement have so small a response (only two bids were received from the eight suppliers on the London Procurement Partnership External Audit framework), the Panel be involved earlier in the process.

Presentations were provided by both Deloitte LLP and BDO LLP. Members sought clarity on a number of points; this was finalised in post-meeting correspondence with Audit Panel members. Following this clarification the Audit Panel approved the recommendation that:

- Deloitte LLP be the preferred bidder, and that subject to internal approvals and the standstill period, a contract award will be made mid-December 2016;

- The decision to be presented to the November Trust board for ratification.

Following the award of a contract, the Trust is required, within 28 days of an appointment being made, to publish a notice to name the external auditor; the length of the appointment; the advice to the Trust board received from the Auditor panel; and, where it has not accepted that advice, the reasons why not. To this end, the following statement is made:

Imperial College Healthcare NHS Trust (the "Trust") has appointed Deloitte LLP as its External Auditor for a three period covering the financial years; 2017-18, 2018-19 and 2019-20. The Trust has the option to extend this contract by two periods of one year at the end of the initial three year term.

The Trust's Audit, Risk & Governance Committee formed the Audit Panel to oversee the tender process.

The Trust issued an Invitation to Quote (ITQ) to all service providers in Lot 1 (External Auditors) of the East of England NHS Collaborative Procurement Hub Framework for Audit & Consultancy Audit services. Following evaluation of bid submissions and clarification sessions the preferred bidder was selected on the basis of the overall highest score.

The recommendation of the preferred bidder has been approved by the Audit Panel and the decision ratified by the Trust board.

Quality impact:

The external auditors audit the quality account as well as the financial statements, and this was taken account of this in evaluating the bids.

Financial impact:

The evaluation required a 50:50 weighting between price and quality.

Risk impact:

The Audit Panel and procurement process was fully compliant with the Local Audit Accountability Act 2014.

Recommendation to the Trust board:

The Trust board is requested to:

- ratify the decision to appoint Deloitte LLP as the Trust's external auditors for an initial period of three years from April 2017, with the option to extend for two periods of one year, and
- agree that this paper forms the notice required by the Act, having been presented to the public and held on the Trust public website.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Jan Aps, Trust co sec	Richard Alexander, CFO	22 November 2016

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

Trust Organisational Strategy 2016

Executive summary:

Our organisational strategy brings together our existing strategies covering important areas such as the Clinical, Quality and Safety, Informatics, Patient and Public Involvement strategies along with key enabling initiatives such as the Finance Improvement Programme into one document, which together form a roadmap to direct us in our journey to deliver on our promise: **Better Heath, for Life.**

The challenges facing the NHS and the Trust are described under the strategic context, with a detailed analysis of our operating environment including strengths, opportunities, risks and a peer comparison of activity and income.

The key themes from each of the strategies set out how they support us in delivering on our corporate objectives and in addressing the three gaps set out in the Five Year Forward View of health and wellbeing, care and quality and finance and efficiency. A review of the implementation of each of the strategies provides progress to date and highlights the key areas of focus going forwards.

In summary our Organisational Strategy comprises three distinct chapters:

Chapter One Strategic Context, overview of the Trust, policy context and strategic drivers

Chapter Two - Our Operating Environment, analysis of income, activity and market position

Chapter Three - Our Strategic Plans to Address the Three NHS Gaps, an overview of our Trust strategies, progress on key areas of their implementation and important next steps.

Quality impact:

The Organisational Strategy sets out the Trust plans for quality and safety, quality improvement and regulatory compliance

Financial impact:

The strategic finance plans and the Finance Improvement Programme provides the approach to delivering a sustainable financial future for the Trust

Risk impact:

The Organisational Strategy document demonstrates assurance that the Trust is implementing its core strategies, progress is being made on delivering on the objectives, and that there is a comprehensive understanding of our activity, income, operational and quality challenges which are addressed through this consolidated Organisational Strategy.

Recommendation to the Trust board:

The Trust board is asked to:

- approve the Organisational Strategy and
- receive a public facing version of this document with key headlines from our business plan in January 2017.

Author	Responsible executive director	Date submitted
Anne Mottram, Director of Strategy	Dr Tracey Batten Chief Executive	23 November 2016

Imperial College Healthcare NHS
NHS Trust

Organisational Strategy v1

November 2016

Our vision is to be a world leader in transforming health through innovation in patient care, education and research


http://www.imperial.nhs.uk/


https://twitter.com/imperialnhs


https://www.facebook.com/ImperialNHS/

Executive Summary

2016/17-2020/21 is likely to be a period of significant and transformational change for the Trust, for the acute and social care provider landscape nationally with the challenge of responding to pressures on NHS funding and calls for increased productivity and efficiency, as national policy changes take effect, and globally as the parameters of health, well-being and disease are re-defined with personalised medicine and technology enhanced healthcare become the norm.

To address these challenges the way we work needs to change. This change requires a strategic approach in how we deliver care that is both high quality and sustainable through the most effective models of care, the effective use of our estate, achieving higher levels of integration and coordination in key partnerships and by better understanding our costs, including clinical services and corporate functions.

Our strategies and supporting initiatives are designed to support the delivery of our corporate objectives and to address the three NHS gaps set out in the Five Year Forward View: Health and wellbeing gap, care and quality gap, finance and efficiency gap. A comprehensive analysis provides key messages to support our ambition to improving financial sustainability which is linked to our business planning process and the North West London Sustainability and Transformation Plan (STP).

Our Clinical Strategy sets out how we will improve services and deliver them in the most clinically and cost effective forms, it addresses challenges and opportunities identified in the SWOT and PESTLE analysis. Our Quality Strategy provides the processes and tool to continuously improve the quality, safety and responsiveness of our services including our commitment to developing Quality Improvement (QI) as a change methodology. Workforce transformation is at the heart of our People and Organisational Development Strategy and we view our staff as our greatest asset. Our IT Strategy sets out a digital map to transforming the way we collect, share and use information to deliver the best care for patients. Our Redevelopment Programme heralds the most significant transformational change since our merger and is closely aligned with the plans of our commissioners, it will allow us to provide care in fit for purpose care environments and to redesign pathways and care models. Achieving a sustainable financial position is a priority. Our financial plans are focused on meeting the significant challenge through a finance improvement programme and are supported by our Estates Strategy and our Private Healthcare Strategy. As one of the UK's six Academic Health Science Centres our AHSC Strategy and Education Strategy outline our plans to deliver excellence in research, teaching and education for the benefits of our patients. These capabilities have been considerably strengthened by extending our AHSC membership to the Royal Brompton and Harefield and the Royal Marsden hospitals, while our Patient and Public Involvement Strategy sets out our approach to involving and engaging with our stakeholders in a meaningful way to ensure patients remain at the centre of all that we do and that their voices are heard.

Our Organisational Strategy brings together all our key strategies and enabling initiatives, which together form a roadmap to direct us in our journey to deliver on our promise: **Better Heath, for Life.**

Contents

	Title	Page
	Executive Summary	**3**
	Introduction	**7**
	Chapter One Strategic Context **1.1 Our Hospitals** **1.2 Our Vision, Ethos, Values and Corporate Objectives** **1.2.1 Vision** **1.2.2 Ethos – our promise** **1.2.3 Values** **1.2.4 Objectives** **1.3 Strategic Context** **1.3.1 Five Year Forward View** **1.3.2 Sustainability and Transformation Plans** **1.3.3 Health Needs of our Population** **1.3.4 Digital Health Care** **1.3.5 Devolution** **1.3.6 One Public Estate** **1.3.7 Shaping a Healthier Future** **1.4 Strategic Financial Context** **1.4.1 NHS Improvement Expectations** **1.4.2 Operating Plan and Commissioning Intentions** **1.4.3 Carter Review of Provider Productivity** **1.4.4 Back Office Consolidation, Pathology and Unsustainable Clinical Services** **1.4.5 Our Estates and Redevelopment Programme**	**8-15**
	Chapter Two Analysis of our Operating Position	**16-27**

	2.1 Our Operating Environment **2.2 Trust Income Trends** **2.2.1 Cost Improvement Programme** **2.2.2 Comparative Analysis Income** **2.2.3 Trust Clinical Income by Main Commissioner** **2.2.4 Market Analysis** **2.2.5 CCG Trend Analysis**	
	Chapter Three Our Strategies to address the Three Gaps: Health & wellbeing, Care & Quality and Finance & Efficiency	**27-39**
	3.1 Clinical Strategy	
	3.1.1 Integrated Care	
	3.1.2 Personalised Medicine	
	3.1.3 Sector-wide Improvements	
	3.1.4 Acute Medical Services	
	3.1.5 Ambulatory Care	
	3.1.6 Improving our Out Patient Experience	
	3.1.7 Developing Models of Care for Integrated and Out of Hospital Care	
	3.1.8 Accountable Care Partnership	
	3.2 Quality Strategy	
	3.2.1 QI Programme	
	3.2.2 Care Quality Commission Inspection	
	3.3 Redevelopment Programme	
	3.3.1 Site Plans	
	3.3.2 Transport and Travel	
	3.4 Estates Strategy	
	3.5 Financial Plans	

	3.5.1 Lord Carter's Review of Provider Productivity	
	3.5.2 North West London Pathology	
	3.6 People and Organisational Development Strategy	
	3.7 Informatics Strategy	
	3.8 Academic Health Science Centre Strategy	
	3.9 Education Strategy	
	3.10 Patient and Public Involvement Strategy	
	3.11 Private Healthcare Strategy	
	3.12 Review of the Organisational Strategy	

Introduction

Imperial College Healthcare NHS Trust (ICHT) was created in 2007, by merging Hammersmith Hospitals NHS Trust and St Mary's NHS Trust to form one of the country's largest acute Hospital Trusts. We have a total operating budget of £1b and over 10,500 staff serving a population of 2m with over 1m annual patient episodes. Our Trust occupies a distinctive position in healthcare. It includes designated regional centres: Hyper Acute Stroke Centre, Major Trauma Centre and Heart Attack Centre; we are one of the largest providers of medical education; with expertise in pioneering new technologies including diagnostics, robotics and simulation; and an established private healthcare function that reinvests all profits to our NHS care. We are consistently rated as one of the leading trusts for effective care with significantly low mortality rates (HSMR, 69.4, SHMI 75.8 and low risk diagnosis 67.9, (2015/16, Dr Foster, 2016).

Together with Imperial College London in 2007 we created the UK's first Academic Health Science Centre (AHSC). We were successfully designated by the Department of Health in 2009 and again in 2014. Our purpose as an AHSC is to utilise excellence in research and education to transform health outcomes and to support the UK's globally competitive position in healthcare related industries by increasing societal and economic gain. Our AHSC's vision is that the quality of life of our patients and populations will be measurably improved by translating our discoveries into medical advances, new therapies and techniques, and by promoting their application in as fast a timeframe as is possible. Our AHSC capabilities were considerably strengthened by the inclusion of the Royal Brompton and Harefield and the Royal Marsden hospitals as new AHSC members in June 2016.

The next five years are likely to see significant and transformational change for the Trust, for the acute and social care provider landscape nationally with the challenge of responding to pressures on NHS funding, as national policy changes take effect and services are delivered through 'place based' models, and as the focus shifts from illness to health and wellness. Traditional care environments will also change as increasingly care is delivered in community settings and population health interventions take effect to improve patient outcomes.

To respond to these opportunities the way we work needs to change. This change requires a strategic approach in how we deliver care that is both high quality, sustainable and delivered through the most effective modes of care, and in how we will transform our organisation to build the resilience needed to face the significant challenges ahead and continuously improve the quality of care for our patients.

Our Organisational Strategy comprises three distinct chapters:

Chapter One: Strategic Context, overview of the Trust, key policies and strategic directives

Chapter Two: Our Operating Environment, analysis of income, activity and market position

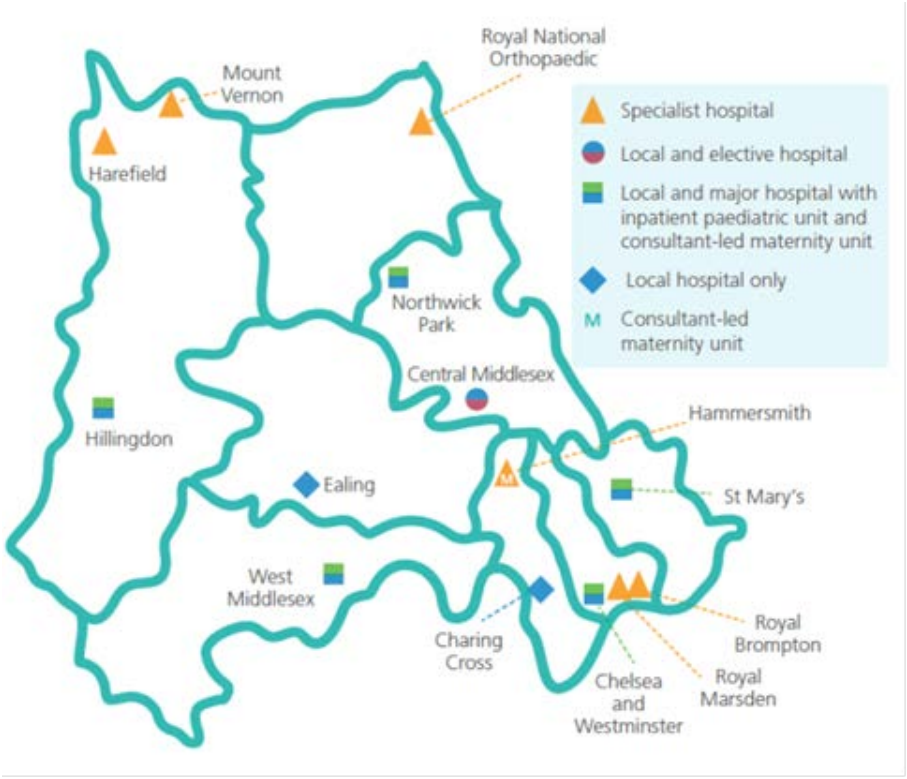
Chapter Three: Our Strategic Plans to Address the Three NHS Gaps, an overview of our Trust strategies, progress on key areas of implementation and important next steps.

Chapter One Strategic Context

1. 1 Our Hospitals

Our hospital sites are positioned across North West (NW) London in a health economy with several acute and specialist providers in close geographical proximity. This is an area of significant urban regeneration with proposed developments around the St Mary's site – Sellar Group Paddington development and the Hammersmith site – Old Oak Common and Park Royal Development Corporation and Imperial West; a biomedical research and translation precinct.

Figure 1 North West London Health Provider Footprint



1.2 Our Vision, Ethos, Values and Corporate Objectives

1.2.1 Vision

Our vision is to be a world leader in transforming health through innovation in patient care, education and research.

1.2.2 Ethos – 'Our promise'

Our promise is **'Better Health for Life'**. To deliver on the promise we developed our organisational values through a large-scale co-design process involving staff at all levels across the organisation and from all occupational groups.

To help everyone to be as healthy as they can be, we want to look out for the people we serve as well as to look after them.

We look after people by providing care, whenever and however we are needed, listening and responding to individual needs. We look out for people by being their partner at every stage of their life, supporting them to take an active role in their own health and wellbeing.

We are one team, working as part of the wider health and care community. We are committed to continuous improvement, sharing our knowledge and learning from others. We draw strength from the breadth and depth of our diversity, and build on our rich heritage of discovery.

By doing all this, we ensure our care is not only clinically outstanding but also as kind and thoughtful as possible. And we are able to play our full part in helping people live their lives to the fullest. Our promise is **Better Health, for Life.**

1.2.3 Values

Kind: *through education and training of our staff and trainees, we will value compassion and kindness as a component of our practice, skills and behaviours development*

Aspirational: *We will strive to be the best, seeking new ways to improve the care we give. We will push the boundaries of scientific knowledge and enquiry in order to promote 'health for life' and ensure all our staff are given opportunities to achieve their maximum potential*

Expert: *We will prioritise developing our people to be experts in their field and provide support for lifelong multi- professional learning*

Collaborative: *We will work and learn together for the benefit of our patients and our local community and we will consult with the local community in developing our services*

1.2.4 Objectives

Our corporate objectives guide our strategic decision-making.

1. To achieve excellent patient experience and outcomes, delivered with care and compassion
2. To educate and engage skilled and diverse people committed to continual learning and improvement.
3. As an Academic Health Science Centre, to generate world-leading research that is translated rapidly into exceptional clinical care.
4. To pioneer integrated models of care with our partners to improve the health of the communities we serve.
5. To realise the organisations' potential through excellent leadership, efficient use of resources and effective governance

1.3 Strategic Context

1.3.1 Five Year Forward View

The Five Year Forward View (FYFV) is the strategy for healthcare across the NHS and sets out plans to address three main gaps in healthcare:

- The health and well-being gap – health inequalities will continue to widen without focus and invest in prevention
- The care and quality gap - harnessing care delivery and technology to address variability
- The funding and efficiency gap - ensuring sustainability across the provider sector

The recommendations require providers to take a more radical approach to delivering services using the most appropriate organisational form for local needs, emphasising 'no one size fits all'. To achieve the transactional and transformational change necessary to support new ways of delivering care a number of initiatives will be implemented: Investment in prevention and public health to

improve NHS sustainability, improving access to information to empower patients, prototypes of four new models of care will be developed with cohort sites; Multispecialty Providers (MCPs), and Primary and Acute Care Systems (PACS), new models to create viable small hospitals and improved health in care homes. In addition a new regime for challenged health systems will be introduced. Urgent and emergency care, maternity and cancer are highlighted as priorities and it proposes a consolidation of specialised services to centres of excellence.

PACS share several characteristics with Accountable Care Partnerships (ACPs). They are commissioned through a capitated funding system to provide services to a specified population and may subcontract elements of their service, with an agreed framework for financial accountability, financial and performance risk management. Recent guidance highlights three core PACS operating models (NHS England, September 2016):

- **virtual** PACS, providers (and potentially commissioners) are bound together by an alliance agreement which overlays the traditional contracts held by each provider with commissioners;
- **partially integrated** PACS, a contract is awarded for the vast majority of health and care services with a single budget but will exclude primary medical care services;
- **fully integrated** PACS, a single contract for all local health and care services and the PACS holds a single whole-population budget

1.3.2 Sustainability and Transformation Plans

i). National Context

Sustainability and Transformation Plans (STPs) are 'place based', five-year plans built around the needs of local populations and which support the implementation of NHS England's (NHSE) FYFV by addressing the three gaps in health and wellbeing, care and quality, finance and efficiency.

STPs are of great importance as they describe the strategic direction agreed by partners across a geographical footprint to develop high quality sustainable health and care and will determine access to the NHS Sustainability and Transformation Fund (STF) which will total £3.4bn by 2020/21. In addition the new Single Oversight Framework from NHS Improvement (NHSI), in effect from October 2016, which is designed to help NHS providers attain, and maintain, Care Quality Commission (CQC) ratings of 'Good' or 'Outstanding', includes progress against STP milestones in its assessment criteria.

ii). Sustainability and Transformation Plans: Regional Context

In developing the NW London STP, the eight boroughs and commissioning groups, acute, mental health and community service providers are working together to improve the health and wellbeing of a population of 2.1m and 2.3m registered patients with an annual health and social care spend of £4b.

Around a third of our patients currently in one of our inpatient beds could be better cared for in the community or at home. Many are frail, elderly people and others with complex, long-term physical and/or mental health conditions. They remain in hospital simply because the support and services they need to go home or to a residential care facility aren't easily available at the right time. Additionally proactive care to help people stay as healthy and independent as possible and manage their own conditions will be very different to the reactive treatment we tend to provide now.

If we continue to provide care without transforming the way we as a footprint provide health and social care, the gap between population level funding and organisational needs becomes ever more unsustainable, with an estimated the shortfall of £1.4b in NW London by 2021.

The vision for NW London is that 'everyone living, working and visiting here has the opportunity to be well and live well – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country' (STP, October 2016). The principles underpinning the NW London STP vision reflect the aims of our Clinical Strategy. Care will be: personalised, localised, co-ordinated, specialised. There are nine priorities in our STP drawn from local place based planning across health and social care:

- Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves
- Improve children's mental and physical health and well-being
- Reduce health inequalities and disparity in outcomes for the top 3 killers: Cancer, heart disease, respiratory disease
- Reduce social isolation
- Reduce unwarranted variation in the management of long term conditions
- Ensure people access the right care in the right place at the right time
- Improve the overall quality of care for people in the last phase of life and enable them to die in their place of choice
- Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population
- Improve consistency in patient outcomes and experience regardless of the day of the week services are accessed

Resources across our footprint will be shifted to focus on achieving change in five delivery areas (DA) that address the nine priority areas of population need across the partner organisations:

- DA1. Radically upgrade prevention and wellbeing
- DA2. Eliminating unwarranted variation and improving long term condition management
- DA3. Achieving better outcomes and experiences for older people
- DA4. Improving outcomes for children &adults with mental health needs
- DA5. Ensuring we have safe, high quality sustainable acute services

iii). Sustainability and Transformation Plans: Local Context

Our Trust Chief Executive, Dr Tracey Batten is the provider representative on the STP leadership group, a member of the Joint NW London Health and Social Care Transformation Group and the programme lead for DA5. Several members of our clinical and managerial teams represent the Trust at the 22 implementation groups and our next steps are to approve our internal governance arrangements for the STP so that we can field the most appropriate representation and share learning and information across our teams.

The final version of the STP was submitted to NHSE and NHSI on the 21st October 2016**.**

iv). Commissioned Specialised Services

Specialised services are those services which require a planning population of more than one million people which treat: Severe or rare conditions, those with serious underlying problems, correct complications following a procedure and require a specialised team working together at a recognised centre. There are plans during 2016 to review and potentially consolidate these services in centres with the best critical mass and outcomes. These plans are being led by NHSE London with input from STP leads and specialist providers across London.

1.3.3 Health Needs of our Population

The UK Academy of Medical Sciences (2015) identified obesity, non-communicable diseases (chronic conditions), and demands of the ageing population and antibiotic resistance as the key heath challenges for the UK over the next 25 years. Several of the associated clinical specialties feature as significant Trust services, for example specialist surgery and specialist medicine including diabetes and renal. Others such as antibiotic resistance are established research themes in our AHSC, including the Biomedical Research Centre (BRC) and the National Institute for Health Research (NIHR) Health Protection Research Unit.

The population of London is around 8.7 million as at 2015. The 13 Inner London boroughs have a population of 3.4 million and the 20 Outer London boroughs a population of 5.2 million. By 2021 London's population is expected to grow to 9.3 million (3.7 million in Inner London and 5.6 million in Outer London), (GLA projections). There are several distinctive characteristics of our local population and the wider London areas, where we also provide care that should be addressed in the planning of our services and in ensuring we are working to accurate assumptions in our strategic plans:

- The proportion of people not born in the UK is highest in the Inner West at 44%, higher than the proportion of people from BME groups in the same area at 32% (Census)
- London has proportionally fewer people aged over 50, particularly in Inner London however the population aged 65 and over is projected to increase by one fifth to one quarter in all regions by mid-2020 (ONS). Across the North West London Clinical Commissioning Groups (NWL CCG) the 65+ age group form a slightly larger proportion of the total population than London, but smaller than England (NWL CCG)
- Net migration peaked in the late 1990s with a slight change from positive to negative net migration between 2011 and 2012. The main driver of London's population growth in the last decade has been the number of births being higher than the number of deaths, rather than the number of people moving in being higher than those moving out (ONS). A number of large-scale redevelopments are planned in NW London, for example Cross Rail, Old Oak Common and Park Royal development and the Sellar Group Paddington redevelopment, which may increase day visitors and bring new residents into the areas served by the Trust
- The official definition of poverty is having a household income that is less than 60% of the national median. The poverty rate for working-age adults in London has risen slightly over the last ten years at 27%, the pensioner poverty rate has seen a significant fall
- The rate of infant mortality in both Inner and Outer London has improved and was below 5 per 1,000 live births in 2010
- The principle causes of premature (<75) death in our area is cancer, followed by cardiovascular disease and chronic pulmonary disease (COPD) (NWL CCG)
- Life expectancy for men and women living in the NW London CCG areas is higher than London and England averages. However, West London CCG has worse health outcomes (NWL CCG, 2016)

Population heath related issues currently seen across NW London include:

- 20% of people have a long term condition
- 50% of people over 65 live alone
- 10 – 28% of children live in households with no adults in employment
- 1 in 5 children aged 4-5 are overweight
- People with serious and long term mental health needs have a life expectancy 20 years less than the average

Projected increases in specific diseases by 2030 with the greatest impact on health and social care across our footprint are a 53% increase in cancer, 40% increase in advanced dementia/Alzheimer's,

36% increase in those living with one or more long term conditions and a 29% increase in severe physical disability (NWL STP, October, 2016).

1.3.4 Digital Health Care

Digital health solutions are essential in supporting greater independence and quality of life for patients and offer more efficient ways of working for healthcare providers. NHS England introduced a funding award to recognise the most digitally advanced trusts and to support them to become Centres of Global Digital Excellence and to drive forward better use of technology in health. The centres will lead the way for the NHS to accelerate developing better information technology, delivering benefits for patients and sharing learning and resources with other local organisations through networks. Each will be partnered with an international organisation to help maximise benefits and learning. We were designated a Global Digital Exemplar by the Department of Health (DH) with our partner Chelsea and Westminster Hospital NHS Foundation Trust (C&W) autumn 2016.

1.3.5 Devolution

Devolution is the transfer of powers and decisions, which would usually be taken by central Government or national bodies to a more local level. The Greater Manchester Combined Authority, an example of an early adopter, signed a devolution agreement in 2014. This included taking control of health and social care spending for the region with full devolution of this £6b budget in 2016/17.

The London Devolution Plan agreed by the Mayor, London CCGs, London borough leaders', NHSE and Public Health England (PHE) sets out the arrangements to redesign £93b in public services (December, 2015). A series of pilots are in progress to pool health and social care budgets at a borough level initially focusing on three priority areas: Prevention, health and care integration and the best use of facilities and land.

1.3.6 One Public Estate

One Public Estate (OPE) is a pioneering initiative delivered in partnership by the Cabinet Office Government Property Unit (GPU) and the Local Government Association (LGA). OPE partnerships work together across the public sector and take a strategic approach to asset management. At its heart, the programme is about getting more from collective assets such as supporting major service transformation such as health and social care integration and benefits reform, unlocking land for new homes and commercial space, or creating new opportunities to save on running costs or generate income. This is encompassed in four core objectives: Creating economic growth (new homes and jobs), more integrated, customer-focused services, generating capital receipts and reducing running costs. London has established a regional programme and our NWL STP includes aspirations to utilise OPE to address footprint estate challenges.

1.3.7 Shaping a Healthier Future

Shaping a Healthier Future (SaHF) is the programme to transform hospital and out of hospital health and care services in NW London. The vision for our Trust sites within the SaHF Programme can be summarised as:

- **St Mary's** to operate as the major acute hospital for emergency care in Inner North West London, with a trauma centre and stroke centre and with the Western Eye Hospital relocating to that site
- **Hammersmith** to operate as the specialist hospital for NW London including specialist medicine and surgical hubs and specialist centres for cardiac and cancer services acting as both a local, regional and national provider
- **Charing Cross** to operate as a local hospital

This vision underpinning SaHF is presented in the NW London STP as providing the enabling context for estates and infrastructure modernisation to deliver care from the most appropriate clinical settings.

In 2013 The Secretary of State for Health agreed that changes to NHS services under SaHF should proceed, in particular those related to Hammersmith and Central Middlesex Hospitals with changes to their A&E services completed in 2014. In addition changes occurred to maternity services in Ealing in 2015 and paediatric services in 2016, with the service transferring to the Trust to address issues with staffing and critical mass.

The Implementation Business Case (ImBC), based on the local acute Trust's business plans and CCG out of hospital plans, is due to be submitted in November 2016.

1.4 Strategic Financial Context

1.4.1 NHS Improvement Expectations

FYFV (2014) made a commitment that the NHS will deliver £22b worth of efficiency savings by 2020/21. However, it was widely recognised that this represented a reduction in national funding in real terms and, together with an ageing population, rising treatment costs, reductions in social care budgets due to local government settlements and increasing patient expectations, posed additional challenges to an already stretched NHS.

In July 2016, the financial reset publication 'Strengthening Financial Performance and Accountability in 2016/17' in the NHS underscored the responsibilities of individual NHS bodies to live within the funding available. Specifically, it confirmed actions to support NHS providers in reducing the annual NHS provider deficit to no more than £580 million with an ambition of £250 million for 2016/17 and a balanced starting position for 2017/18 based on the full year effect of the measures taken.

In September 2016 joint NHSI and NHSE 'NHS Operational Planning and Contracting Guidance for 2017-2019' was published. This reiterated that the provider sector will be expected to achieve aggregate financial balance in each of the two years of the operational plan after taking into account deployment of the £1.8b Sustainability and Transformation Fund (STF). The clear expectation is that 'sustainability funding must deliver at least a pound-for-pound improvement in the aggregate financial position' (NHSI, 2016).

All trusts must deliver an agreed financial control total in each year. Delivery of these control totals is a core part of NHSI's new Single Oversight Framework; with control totals developed using an impact assessment model for a range of known factors at an individual trust level.

Our financial goal in the 2015/16 plan was to allow a deficit of £18.5m for one year (largely driven by the removal of the subsidy for complex specialist care) before returning to surplus and long-term financial sustainability. However, despite the trust meeting its statutory financial performance targets, 2015/16 turned out to be an extremely challenging year with the Trust achieving an operational outturn of a £30.1m deficit, and a final deficit outturn after provisions of £47.9m. This has made 2016-17 more challenging with the Trust now forecasting a £41m deficit, following agreement of our control total with NHSI, and a CIP programme of £58m. To support delivery of our financial targets, earlier this year the Trust initiated a Financial Improvement Programme supported by PwC. Section 3.5 outlines our financial plans.

1.4.2 Operating Plan and Commissioning Intentions
Looking forward, NHSI have set out a challenging expectation for organisations to develop two year operational planning and contracting covering 2017/18 and 2018/19 by the end of December 2016.

Commissioning intentions issued in October 2016 herald a new approach from NHS England who will work in closer collaboration with 'local commissioners' on specialised service commissioning, developing the shared priorities of the STPs and achieving efficiencies. Some of efficiency gains are identified as occurring through consolidation; for example supply chain and procurement, improvements to pharmacy, and moving some services into centres of excellence. Eliminating variation is an area of focus: standardising non-national tariff prices and removing unwarranted variation in clinical care. An important intention which is strongly aligned with our clinical strategy is a move towards developing Accountable Care Partnerships (ACP), progressing with shadow budgets and an initial focus on the older adult population.

1.4.3 Carter Review of Provider Productivity
Against an expectation that NHS providers will deliver efficiencies of 2-3% per year, which in real terms sets a requirement for 10-15% in cost reduction by 2012, Lord Carter conducted a review of productivity and efficiency in acute providers to identify improvement opportunities and highlighted that £59b could be saved by better use of NHS resources. The review focused on the use of resources in areas of clinical staffing, pharmacy and medicines management, diagnostics and imaging, procurement, back-office functions and estates and facilities. Unwarranted variations were found in the costs of certain procedures and practices between the most and least expensive trusts using the adjusted treatment cost (ATC) as one measure of cost per given output

1.4.4 Back Office Consolidation, Pathology and Unsustainable Clinical Services
In June 2016, NHSI wrote to all providers asking them to submit a high-level summary of the opportunities for further action to tackle pay bill growth, implementing Lord Carter's recommendations on back office and pathology services, and identifying new ways of providing unsustainable services. Actions in these area were thought to be essential in reducing the provider sector deficit in 2016/17 to around £250m, with a full year effect that would result in a balanced 'run rate' position going into 2017/18. In July of that year providers were asked to submit a high-level summary of the opportunities for consolidation and re-provision aligned with local STPs as actions to progress during 2016/17 to improve efficiency and quality.

1.4.5 Our Estates and Redevelopment Programme
Recent figures detailing the scale of the NHS backlog maintenance programme show that the overall costs to eradicate the total backlog increased by 15 per cent last year to almost £5bn as organisations reduce their levels of capital investment. In 2015-16, NHS providers had high risk maintenance costs of £775m, compared to £458m in 2014-15 and £357m in 2013-14 (HSJ, October 2016).

In terms of our physical infrastructure, we have not carried out any major estate redevelopment since the merger in 2007. Many of our buildings are old and far from optimal for future care model requirements. We have a significant issue related to the size and cost of our total backlog maintenance requirements which currently stands at £1.3 billion. This means that the Trust alone is responsible for just over one fifth of the NHS's total backlog maintenance costs and that 17% of all NHS high risk maintenance costs reside in our estate.

Chapter Two Analysis of our Operating Position

2.1 Our Operating Environment

In reviewing the opportunities and risks that we need to respond to over the next five years we carried out a comprehensive SWOT and PESTLE analysis, involving staff from clinical and corporate divisions with the findings shown below in table 1 and 2.

Table 1 SWOT

Strengths	Weaknesses
Skilled, diverse, increasingly engaged workforce Largest provider of elective care in North West London (NWL) and main tertiary centre Major provider of acute emergency care in NWL e.g. Major Trauma Centre (MTC), Hyper Acute Stroke Unit (HASU), Adult and Paediatric A&E, Heart Attack Centre Range and diversity of clinical services Each Hospital site plays an important role in the local community Sites occupy prime London locations Supportive and engaged Charity Partnership with Imperial College London and AHSC Track record of innovation Clinical outcomes above expected rates for many metrics, e.g. SHMI, HSMR Largest Biomedical Research Centre award Comprehensive research portfolio with well-established infrastructure and partnerships, capabilities in genomics, big data, rare diseases Commitment to embedding Trust values Strong leadership and management training programmes	Care Quality Commission (CQC) overall rating of 'requires improvement' Functional suitability of the Trust estate and significant backlog maintenance costs Operational and capacity challenges to meet NHS Constitution standards Legacy effect regarding integration and co-ordination in some areas Areas with sub-optimal productivity Medical trainees satisfaction with Trust training experience in some specialities Full implementation of a comprehensive cost containment process Capacity and capabilities to deliver clinical and administrative support to 7 day services including consistent operating procedures for clinical admin processes Patient experience below expectations in some areas Staff experience below expectations in some areas Routine availability, use of business intelligence data Multi-site working: silos, duplication or non-consolidation of services, financial and travel impact
Opportunities	**Threats**
NWL STP and Trust CEO as a lead for Delivery Area 5 Developing partnership with Chelsea and Westminster NHS Foundation Trust Realising the predicted Carter Review savings Significant redevelopment investment in surrounding areas: improved transport, regeneration and increased population/users of services e.g. Sellar Group, Old Oak Common and Park Royal , Cross Rail, Imperial West Redevelopment of sites to create fit for purpose facilities to improve efficiencies, patient and staff experience Improving stakeholder relations as part of transformation works Building a stable leadership team IT Global Excellence Award, Electronic Patient Record, Care Information Exchange to support new ways of working/new models of care Optimising AHSC benefits and AHSC extended membership member of AHSN BRC reaccreditation successful in 2016 Building our brand: **Better Health for Life**	Unprecedented financial challenge across the NHS and impacts on quality of care Trust higher than average Cost Improvement Programmes (CIP) Achieving Good or above at CQC re- Affordability of proposed redevelopment scheme Planning blight due to major strategic change across the local health economy Challenge of delivering cost improvement programmes in full to achieve financial sustainability Maintaining organisational resilience to consistently meet quality, financial, regulatory, performance and access requirements Unfunded or marginally funded growth Specialist tariff does not fully reflect acuity and training costs Reductions arising from reviews of Specialist Commissioned services Commissioner challenge process

Agreeing where we wish to collaborate and where we wish to compete for services over a strategic period Working collaboratively with GPs, Commissioners and partners to deliver integrated care e.g. ACP Preventative health and wellbeing Transformation resources and programmes e.g. Out Patient Transformation, Clinical Strategy Implementation Programme, North West London Pathology, Macmillan Private healthcare and reputational gains from Royal births Embedding quality improvement (QI) methodology	Changes to funding of pass through items Interruption of services due to ageing equipment Impact of New Care Models and community focused tenders on Trust activity in the short to mid term Reductions in market share arising from sector reconfigurations Continuing challenges in recruitment of hard to recruit groups and achieving safe staffing levels across the Trust Losses re National Education Tariff

Table 2 PESTLE

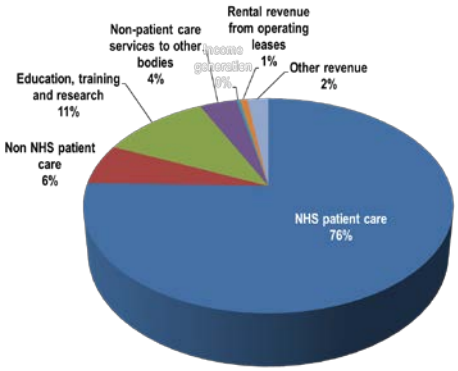
Political	**Economic**	**Social**
Gap between patient needs and NHS resources of £30bn per year by 2020/21 Policy changes reduce public health budgets with knock-on effects to NHS Devolution in London brings changes to health and social funding requiring new ways of moving across health economy Political will/pressure impacts sector and Trust redevelopment plans Impact of Brexit on NHS international workforce	Sustainability of NHS funding model International migration (8.5% of the 13% predicted growth for London Competition from independent providers in tenders where the Trust is unable to match or better service costs High calibre strategic partnerships are required to advise on commercial options for estates redevelopment NHS pay and changes to terms and conditions may lead to workforce challenges including recruitment and retention Impact of Brexit on UK credit rating, borrowing and land sales	Challenges of an ageing, increasing and diverse population with 13% growth predicted for London overall (7% England) and 21.5% increase in London population aged 65 plus*. Local population increases, transient and residential arising from major developments People are living longer and need a wider range of services over a longer period of time The majority of illnesses treated by the NHS are caused by obesity, smoking or alcohol , presenting opportunities for greater involvement in preventative and population based health and well being Increasing variety and uptake of social media used in decision making re where to receive care, in sharing reviews and information across online populations and in self-management of illness
Technological	**Legal**	**Environmental**
NHS Innovation Accelerator Programme – Trust a designated site for Diabetes Biological devices will disrupt acute	Uncertainties regarding EU legislation and the UK position Legislatory and regulatory changes arising from establishment of NHS	Trust estate and ageing equipment will pose greater challenges to safety, productivity and experience if

treatment settings with more patients able to be monitored at home Reducing costs of gene sequencing will allow greater access to testing Developing capabilities in heath informatics/big data analysis not included in most NHS training programmes skills gap	Improvement Increased awareness of litigation and expectations results in increased costs and possible media attention	solutions not implemented Drive for energy efficiencies and carbon neutral delivery require Trust to increase its focus on sustainable environment

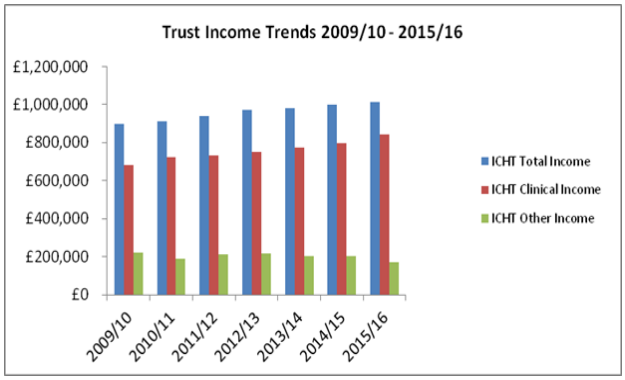
2.2 Trust Income Trends

A trend analysis of our income from 2009/10 to 2015/16 shows a 2% increase Compound Annual Growth Rate (CAGR) on **total income,** with 1.7% increase from 2014/15 to 2015/16. **Clinical income** across the period has increased by 3% CAGR, with a 5.7% increase from 2014/15 to 2015/16. **Other income** has decreased over the period by -3% CAGR, with a -16.6% decrease from 2014/15 to 2015/15

Figure 2. Sources of Income



Graph 1. Trust Income Trends 2009/10 – 2015/16



2.2.1 Cost Improvement Programme

During 2015/16 we delivered 80% of our cost improvement programme of £36.1m, a slight reduction on CIP delivery in 2014/15, 81%.

Table 3 Cost Improvement Programme (CIP) Delivery 2015/16

£m's	2014/15 (Actual)	2015/16 (Actual)
Target	£49.3	£36.1
Achieved (£)	£39.7	£28.9
Achieved (%)	81%	80%

2.2.2 Competitor Analysis Income

To analyse our performance in securing income, two peers were selected based on their size, service portfolios and academic credentials, University College Hospital NHS Foundation Trust (UCLH) and Guys and St Thomas' NHS Foundation Trust (GST) with a third, Chelsea and Westminster NHS Foundation Trust (C&W) selected as one of our top peers for NWL CCG activity.

Over the set period our total income and clinical income increased at a slower rate than the selected

peers and for 'other income' ours reduced more than peers, closely followed by UCLH. C&W* saw the highest increases across all three income types and this is thought to be due to the full effect of the consolidation of accounts post-acquisition of the West Middlesex Hospital.

Table 4. Comparative Analysis by Income Type CAGR 2009-2016

Trust	All Total Income	Clinical Income	All Other Income
ICHT	2%	3%	-3%
UCLH	3%	4%	-1%
GST	3%	4%	0%
C&W*	8%	9%	8%

Source: Annual Accounts

2.2.3 Trust Clinical Income by Main Commissioner

Our largest single funding source as payment for clinical activity is the NW London CCGs, £370m in 2015/16 which increased by 2.4% from £361m in 2014/15 and equates to 49% of our total clinical income. The second largest single funding source is NHSE which increased by 2.3% to £307m in 2015/16 and makes up 41% of our total clinical income.

Graph 2. Trust Clinical Income by Commissioner

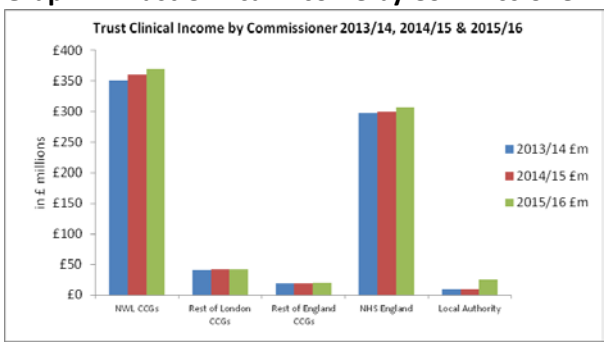
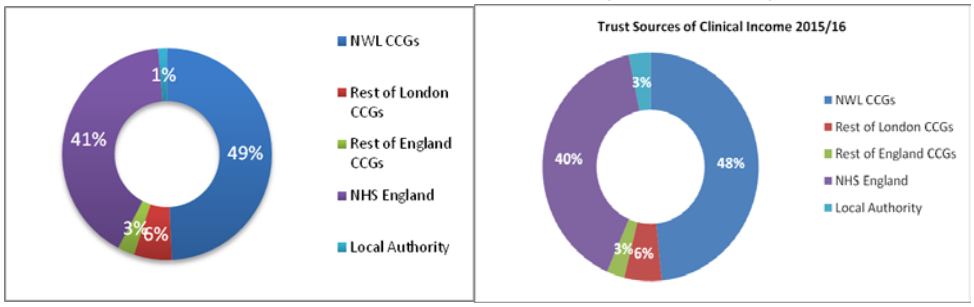


Chart 1 & 2. Trust Sources of Clinical Income 2014/15 and 2015/16



2.2.4 Market Analysis

The Trust provides services to a local population through commissioning arrangements with the eight NW London CCGs (NWL), the remaining 23 CCGs are categorised as 'Rest of London'. The map below shows the NWL CCGs and the Rest of London CCGs boundaries.

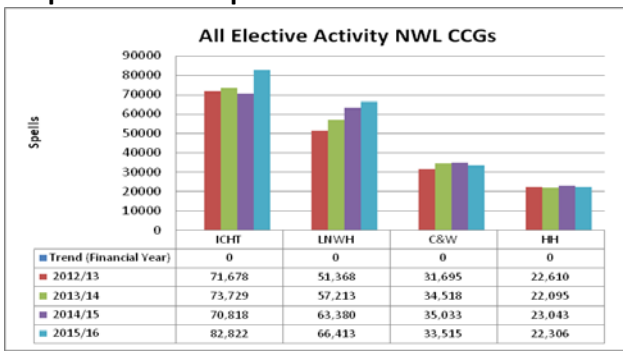
Figure 3. CCG Boundaries NWL and Rest of London CCGs

The London provider landscape comprises a high concentration of acute and tertiary hospitals resulting in competition for certain types of clinical activity and specialities. A number of important recent developments may impact on the Trust's competitive position: Within the NW London (NWL) sector the recent merger of London North West Hospitals (Northwick Park Hospital, St Marks Hospital, Central Middlesex Hospitals, Ealing Hospital merged on the 1st October 2014) has resulted in the consolidation of market share and patient pathways for the merged organisation. The acquisition of West Middlesex University Hospital NHS Trust (WMUH) by Chelsea and Westminster NHS Foundation Trust (C&W) on the 1st September 2015 provides an expanded population and opportunities to re-direct patient flows in some clinical services.

2.2.5 CCG Trend Analysis

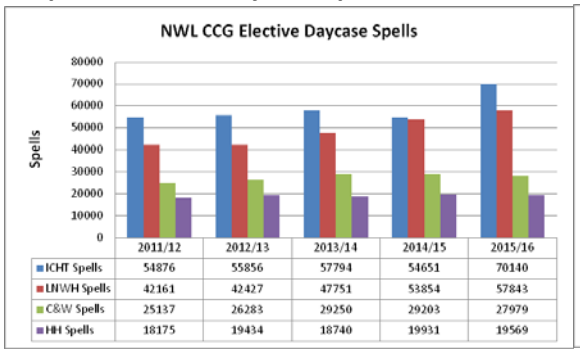
i). NWL CCG Elective

Graph 3. Elective Spells NWL CCGs



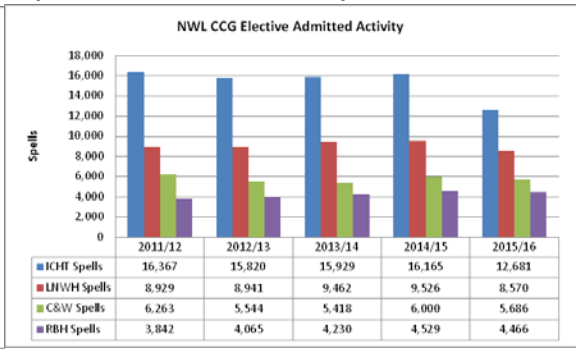
The **NWL CCG elective** market increased by 4.1% (spells). **ICHT** activity increased by 16.9%. The closest peer was **London North West Hospitals NHS Trust (LNWH)** who saw an increase of 4.7%. Reductions were seen at **Chelsea and Westminster Hospital NHS Foundation Trust (C&W)** -4.3%, and at the **Hillingdon Hospital NHS Foundation Trust (HH)** -3.1%

Graph 4. Elective Daycase Spells NWL CCGs



	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Spells	54876	55856	57794	54651	70140
LNWH Spells	42161	42427	47751	53854	57843
C&W Spells	25137	26283	29250	29203	27979
HH Spells	18175	19434	18740	19931	19569

Graph 5. Elective Admitted Spells NWL CCGs



	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Spells	16,367	15,820	15,929	16,165	12,681
LNWH Spells	8,929	8,941	9,462	9,526	8,570
C&W Spells	6,263	5,544	5,418	6,000	5,686
RBH Spells	3,842	4,065	4,230	4,529	4,466

Elective activity data includes day case and admitted elective activity and it is therefore important to analyse changes for both types of elective activity to identify factors driving growth.

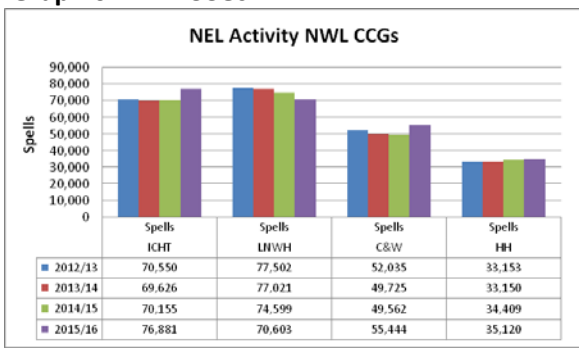
In 2015/16 there was a 28% increase in **NWL CCG daycase elective activity**, an extra 15,489 spells.

For ICHT **Admitted elective activity** there was a 21.5% reduction, which is 3,484 less spells completed in the previous year.

For elective daycase activity C&W and HH saw reductions. All the top four providers by volume saw decreases in elective admitted activity.

ii). NWL CCG NEL

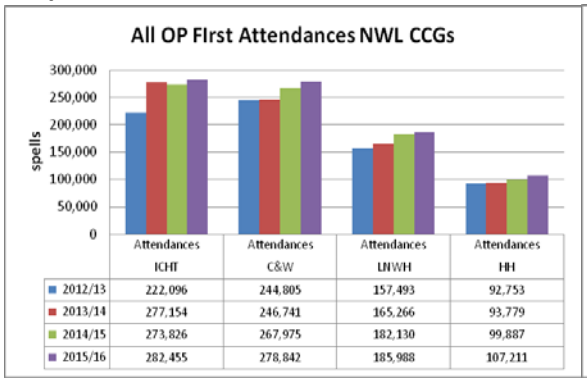
Graph 6. NWL CCGs NEL



	Spells ICHT	Spells LNWH	Spells C&W	Spells HH
2012/13	70,550	77,502	52,035	33,153
2013/14	69,626	77,021	49,725	33,150
2014/15	70,155	74,599	49,562	34,409
2015/16	76,881	70,603	55,444	35,120

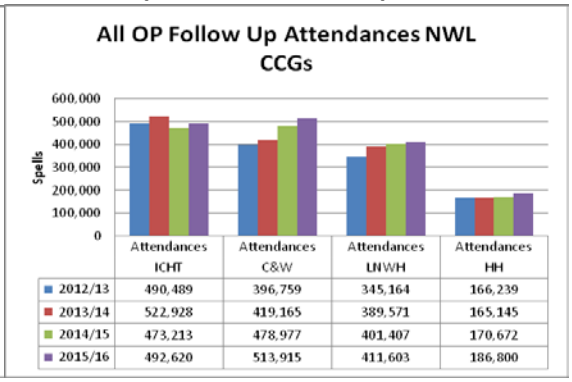
The overall **NWL CCG NEL** market grew by 3.1%, **ICHT NWL NEL activity** increased by 9.58%. C&W had the greatest increase at 11.86%. HH increased by 2.06%. The closest peer by volume, LNWH saw a reduction of -5.35%

Graph 7. NWL OP First Attendances



	Attendances ICHT	Attendances C&W	Attendances LNWH	Attendances HH
2012/13	222,096	244,805	157,493	92,753
2013/14	277,154	246,741	165,266	93,779
2014/15	273,826	267,975	182,130	99,887
2015/16	282,455	278,842	185,988	107,211

Graph 8. NWL Follow up Attendances



	Attendances ICHT	Attendances C&W	Attendances LNWH	Attendances HH
2012/13	490,489	396,759	345,164	166,239
2013/14	522,928	419,165	389,571	165,145
2014/15	473,213	478,977	401,407	170,672
2015/16	492,620	513,915	411,603	186,800

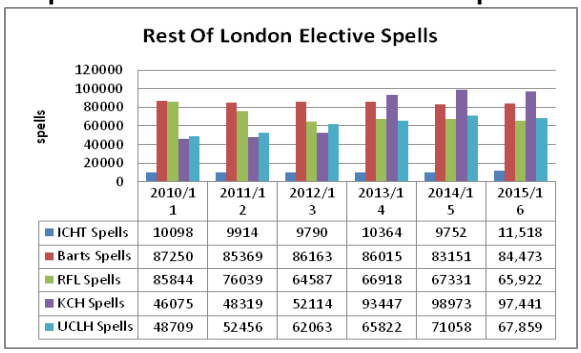
The **NWL CCG OP First** market grew by 6.3%. **ICHT** increased by 3.15%, +8,629 attendances. **C&W** were the next largest provider and their activity increased by 4.05%. **LNWH** increased by 2.11%. The largest increase was at **HH** 7.33%.

The **NWL OP follow up** market decreased by -0.68%. **ICHT** saw increased activity 4.1%, +19,407 spells. **C&W**, the largest single provider, saw an increase of 7.29%. **LNWH** increased by 2.5%, and **HH** increased the most at 9.44%.

iii). Rest of London CCGs

Data is shown in spells for the Trust and our top four peers by volume.

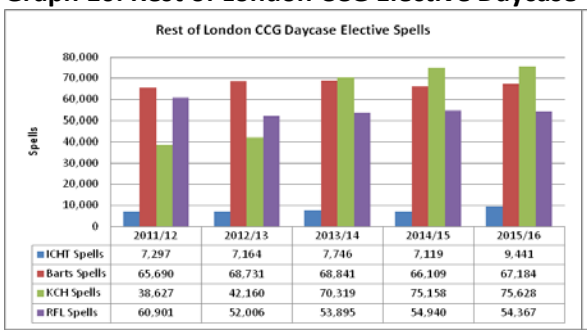
Graph 9. Rest of London CCG Elective Spells



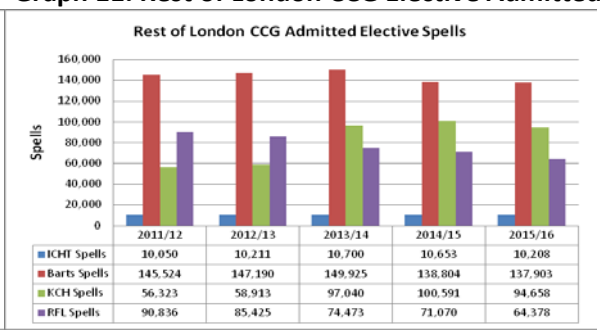
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Spells	10098	9914	9790	10364	9752	11,518
Barts Spells	87250	85369	86163	86015	83151	84,473
RFL Spells	85844	76039	64587	66918	67331	65,922
KCH Spells	46075	48319	52114	93447	98973	97,441
UCLH Spells	48709	52456	62063	65822	71058	67,859

ICHT Elective activity for **Rest of London CCGs** increased by 15.3%. Barts' activity increased at a smaller rate of 1.5%, Reductions were seen at RFL, KCH and UCLH.

Graph 10. Rest of London CCG Elective Daycase Graph 11. Rest of London CCG Elective Admitted



	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Spells	7,297	7,164	7,746	7,119	9,441
Barts Spells	65,690	68,731	68,841	66,109	67,184
KCH Spells	38,627	42,160	70,319	75,158	75,628
RFL Spells	60,901	52,006	53,895	54,940	54,367



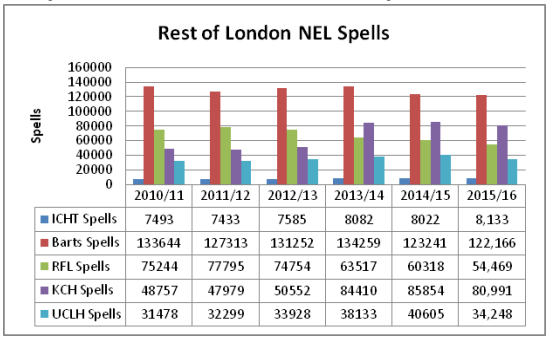
	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Spells	10,050	10,211	10,700	10,653	10,208
Barts Spells	145,524	147,190	149,925	138,804	137,903
KCH Spells	56,323	58,913	97,040	100,591	94,658
RFL Spells	90,836	85,425	74,473	71,070	64,378

Using the same breakdown into elective admitted and elective day case activity**,** ICHT **Rest of London elective daycase** activity increased by 24.5%, small increases were seen at Barts and KCH, with a small reduction at RFL, the top providers by volume.

All four providers saw reductions in **admitted electives** for **Rest of London CCG** during 2015/16.

iv). Rest of London NEL

Graph 12. Rest of London NEL Spells

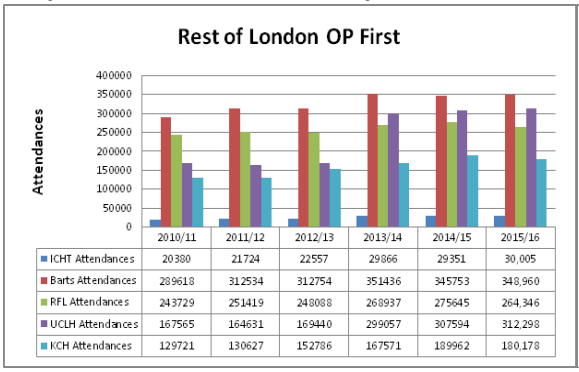


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Spells	7493	7433	7585	8082	8022	8,133
Barts Spells	133644	127313	131252	134259	123241	122,166
RFL Spells	75244	77795	74754	63517	60318	54,469
KCH Spells	48757	47979	50552	84410	85854	80,991
UCLH Spells	31478	32299	33928	38133	40605	34,248

ICHT NEL activity for Rest of London CCGs increased by 1.3%. Reductions were seen at Barts, RFL, KCH and UCLH.

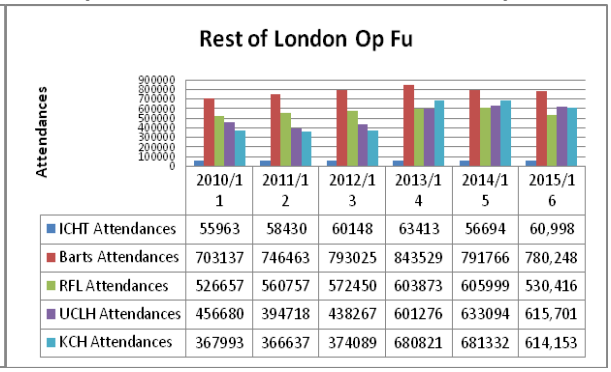
v). Rest of London OP

Graph 13. Rest of London Outpatient First



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Attendances	20380	21724	22557	29866	29351	30,005
Barts Attendances	289618	312534	312754	351436	345753	348,960
RFL Attendances	243729	251419	248088	268937	275645	264,346
UCLH Attendances	167565	164631	169440	299057	307594	312,298
KCH Attendances	129721	130627	152786	167571	189962	180,178

Graph 14. Rest of London OP Follow up



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
ICHT Attendances	55963	58430	60148	63413	56694	60,998
Barts Attendances	703137	746463	793025	843529	791766	780,248
RFL Attendances	526657	560757	572450	603873	605999	530,416
UCLH Attendances	456680	394718	438267	601276	633094	615,701
KCH Attendances	367993	366637	374089	680821	681332	614,153

ICHT **OP First attendances for Rest of London CCGs** increased by 2.1%. Barts increased by 6.6%**,** UCLH increased by 1.5%. Reductions were seen at RFL and Kings.
ICHT **OP Follow up attendances for Rest of London CCGs** increased by 7%. Barts, UCLH, RFL and KCH all reduced their OP Follow up attendances with RFL having the greatest reduction at -14%.

vi). Market Share NWL and Rest of London

Table 5. Market Share Analysis NWL CCGs

NWL CCGs Elective	ICHT %	LNWH %	C&W %	HH %
2012/13	30.03	21.52	13.28	9.47
2013/14	29.51	22.9	13.82	8.84
2014/15	27.47	24.58	13.59	8.94
2015/16	30.68	24.61	12.42	8.26

NWL CCGs NEL	ICHT %	LNWH %	C&W %	HH %
2012/13	26.75	29.39	19.73	12.57
2013/14	26.58	29.4	18.98	12.65
2014/15	26.67	28.36	18.84	13.08
2015/16	28.37	26.05	20.46	12.96

NWL CCGs OP First	ICHT %	C&W %	LNWH %	HH %
2012/13	25.95	28.61	18.4	10.84
2013/14	28.97	25.79	17.27	9.8
2014/15	26.65	26.08	17.72	9.72
2015/16	25.86	25.53	17.03	9.82

NWL CCGs OPF	ICHT %	C&W %	LNWH %	HH %
2012/13	26.06	21.08	18.34	8.83
2013/14	22.12	17.73	16.48	6.98
2014/15	19.98	20.23	16.95	7.21
2015/16	20.93	21.83	17.49	7.94

Table 6. Summary of Market Analysis Rest of London CCGs

Rest of London Elective	ICHT %	Barts %	KCH %	UCLH %
2012/13	8.33	8.76	5.35	7.44
2013/14	8.39	8.53	8.62	7.71
2014/15	7.85	8.04	8.99	8.16
2015/16	9.13	8.14	8.8	7.72

Rest of London NEL	ICHT %	Barts %	LNWH %	KCH %
2012/13	7.11	11.93	7.34	4.58
2013/14	7.13	12.31	7.38	7.73
2014/15	7.11	11.19	7.05	7.83
2015/16	7.75	11.14	6.73	7.38

Rest of London OP First	ICHT %	Barts %	C&W %	RFH %
2012/13	7	8.78	8.2	7.52
2013/14	8.02	9.02	7.63	7.55
2014/15	7.57	8.39	7.91	7.38
2015/16	7.3	8.12	7.65	6.97

Rest of London OP Fu	ICHT %	Barts %	RFH %	UCLH %
2012/13	6.54	9.07	7.33	5.56
2013/14	6.42	8.89	7.22	7.1
2014/15	5.86	8.3	7.32	7.53
2015/16	6.1	8.5	6.58	7.67

Source: Dr Foster 2016

ICHT market share for the **NWL elective market** has grown by 3.21%, while peers (by size of market share) has either decreased (C&W) or remained largely static (LNWH, HH). The Trust's market share for the **NWL NEL market** increased by 1.7%, C&W had a comparable increase at 1.62%. Reductions were seen at LNWH, the closest peer by volume, and HH.

Three of the largest providers in the **NWL OP First** market saw reductions in market share, including the Trust, -0.79%. All top four providers saw increases in **NWL OP Follow up** market share, for the Trust this is 0.95%. C&W have the largest single market share.

For **Rest of London elective** the Trust's market share increased by 1.28%. Reductions in market share were seen at UCLH and at a smaller rate at KCH, with a very small increase at Barts. For **Rest of London NEL** the Trust was the only provider with an increase in market share, 0.64% and has the largest single market share.

All the top four providers for **Rest of London OP First** saw reductions in market share. Barts has the largest single market share. Small increases in **Rest of London Follow up** market share were seen by the Trust, 0.24%, Barts, the single biggest market share holder, and UCLH with reductions at RFH.

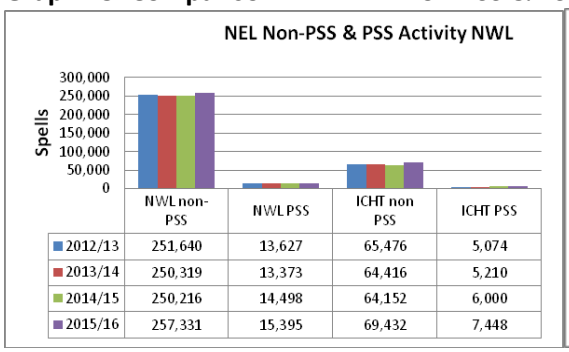
vii). Commissioned Specialised Services

In NW London there are nine hospitals that provide specialised services. The main providers of specialised acute services are the Trust (£287m) and Royal Brompton and Harefield (£226m). Specialised mental health services are provided by West London Mental Health (£120m). The remaining six providers (C&W, LNWH, Central and North West, HH, Tavistock and Portman, and St Peter's Andrology) together account for a further £251m (NWL STP, October 2016). NW London also provides specialised services to a population that extends beyond its geographical footprint.

Specialised services provide 41% of our clinical income and many are aligned with our research themes across the BRC. Our market share for all specialised services in the NW London sector increased from 41.4% in 2014/15 to 48.4% in 2015/16, an increase of 7% in total.

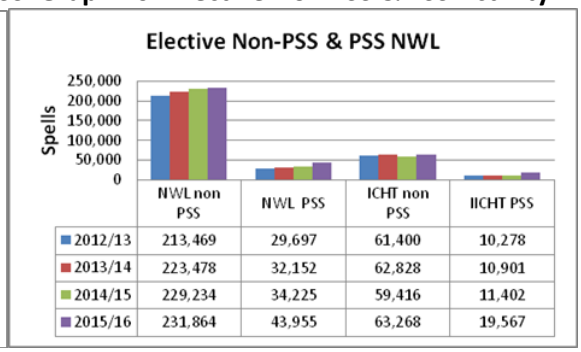
Benchmarking activity on Prescribed Specialist Services (PSS) contains an almost full data set of specialised services with some differences in procedures and is used here to analyse Trust and peer trends.

Graph 15. Comparison NWL NEL Non-PSS & PSS



	NWL non-PSS	NWL PSS	ICHT non PSS	ICHT PSS
2012/13	251,640	13,627	65,476	5,074
2013/14	250,319	13,373	64,416	5,210
2014/15	250,216	14,498	64,152	6,000
2015/16	257,331	15,395	69,432	7,448

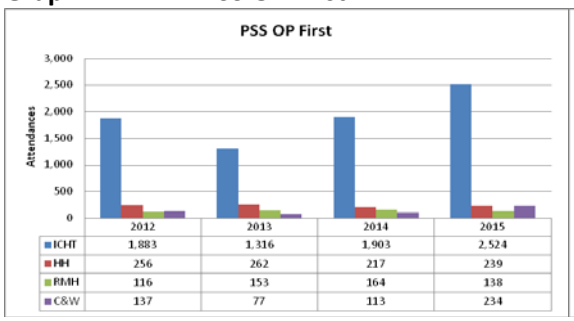
Graph 16. Elective Non PSS & PSS Activity NWL



	NWL non PSS	NWL PSS	ICHT non PSS	IICHT PSS
2012/13	213,469	29,697	61,400	10,278
2013/14	223,478	32,152	62,828	10,901
2014/15	229,234	34,225	59,416	11,402
2015/16	231,864	43,955	63,268	19,567

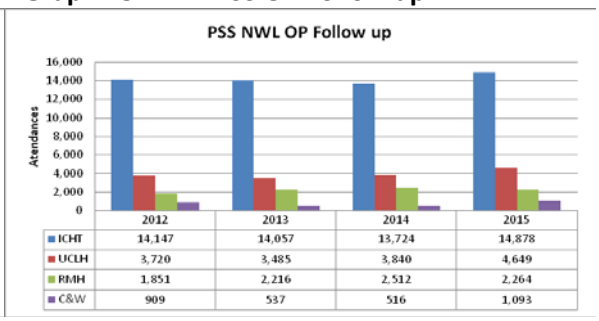
ICHT NEL PSS activity increased by 19%. **ICHT Elective PSS** activity increased by 41%

Graph 17. NWL PSS OP First



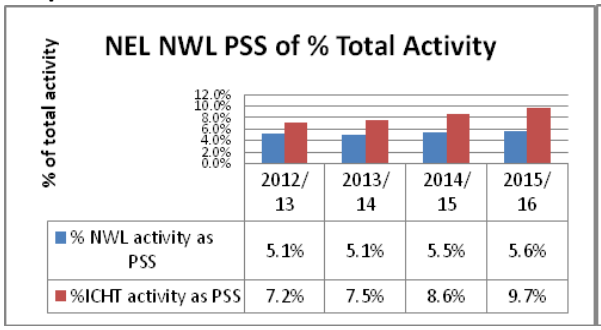
	2012	2013	2014	2015
ICHT	1,883	1,316	1,903	2,524
HH	256	262	217	239
RMH	116	153	164	138
C&W	137	77	113	234

Graph 18. NWL PSS OP Follow up



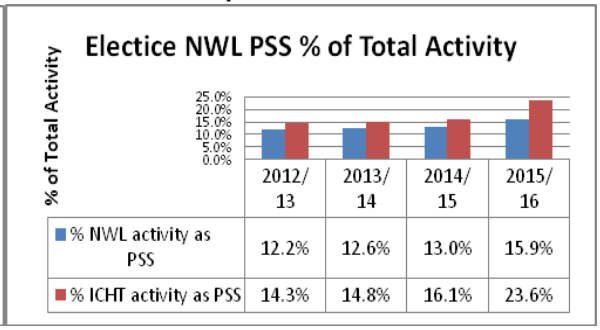
	2012	2013	2014	2015
ICHT	14,147	14,057	13,724	14,878
UCLH	3,720	3,485	3,840	4,649
RMH	1,851	2,216	2,512	2,264
C&W	909	537	516	1,093

Graph 19. NWL PSS NEL



	2012/13	2013/14	2014/15	2015/16
% NWL activity as PSS	5.1%	5.1%	5.5%	5.6%
%ICHT activity as PSS	7.2%	7.5%	8.6%	9.7%

Graph 20. NWL PSS Elective

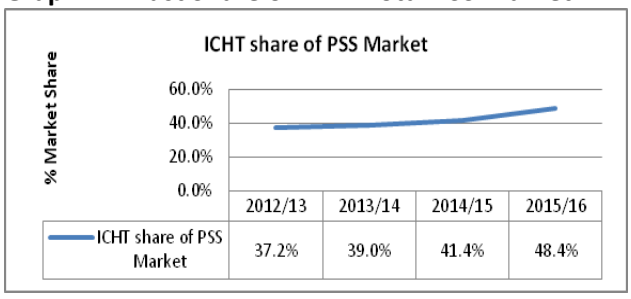


	2012/13	2013/14	2014/15	2015/16
% NWL activity as PSS	12.2%	12.6%	13.0%	15.9%
% ICHT activity as PSS	14.3%	14.8%	16.1%	23.6%

In 2015/16 **PSS as a percentage of total activity in NWL NEL** was 5.6%, static from the previous year. **ICHT's PPS as a percentage of total activity in NWL NEL** activity increased by 1% to 9.7%.

In 2015/16 **PSS as a percentage of total activity in NWL for electives** increased by 2.9% to 15.9% ICHT's increase was greater at 7.5%, this is 23.6% of our total NWL activity.

Graph 21 Trust Share of NWL Total PSS Market



	2012/13	2013/14	2014/15	2015/16
ICHT share of PSS Market	37.2%	39.0%	41.4%	48.4%

ICHTs overall share of the NWL PSS total market increased by 7% in 2015/16, and has increased albeit at a slower rate, every year since 2012/13.

viii). Key Messages

- From 2009-2016 our overall income has grown– the greatest increase was in clinical income in 2015/16,
- Compared to selected peers our income over the defined period grew less quickly with 'other income' decreasing more than selected peers
- There are increases in clinical income for NWL CCG and NHSE however, this increase in income did not fully match the increase in activity for these commissioning sources
- Our greatest activity increases were in NWL (and increases in Rest of London CCG) elective activity. At a granular level of analysis the growth is due to significant increases in daycase elective activity, a trend also seen in the top providers as peers by volume suggesting that a change in clinical model of care might be occurring
- NWL NEL activity increased by 10% (and by 12% for C&W) not all peers saw an increase in NEL as LNWH's activity reduced by 5%
- For the Rest of London CCGs elective activity again increased due to increases in daycase activity – in patient elective activity decreases for all top peer providers
- For Rest of London NEL we had a small increase in activity while peers activity was slightly reduced
- NWL CCG and Rest of London OPD follow ups increased
- A considerable proportion of our income and activity is from commissioned specialised services. Our market share for PSS increased by 7% to 48% of the NWL market. These services are being reviewed nationally and in the NWL STP
- Overall for NWL and Rest of London CCGs are activity has increased in all types – with the exception of small reduction in OP first Rest of London, We now provide one third of all elective and NEL activity for NWL CCGs

There are several factors thought to be contributing to overall changes in activity:

- Improved data capture as a result of the implementation of the electronic record and enhanced staff training
- Significant increases in daycase elective procedures and a subsequent reduction in admitted elective activity thought to be due in part to changes in clinical care models
- Some significant changes at a service level such as large increases in oncology daycase, the transfer of maternity services from Ealing Hospital.

These high level messages on trends in activity and income support our plans to develop new models of care and an ACP to address issues of rising NEL demand, to address the most appropriate care setting for OP follow ups and to play our role in developing a more sustainable NW London footprint through the NWL STP and in particular the work streams related to specialised commissioning and provider productivity.

Chapter Three Our Strategies to Address the Three Gaps: Health & Wellbeing, Care & Quality, and Finance & Efficiency

3.1 Clinical Strategy

Our Clinical Strategy was developed through a large-scale engagement process and approved by the Board in July 2014 and sets out our vision and the processes necessary to achieve substantial clinical transformation. The strategy considers both the needs of the local community and those of the wider NW London Sector. Central to our improvement journey is the redevelopment of our three main sites to provide 21st Century accommodation for our patients, services and staff whilst allowing co-location of services as clinically appropriate and the implementation of our Quality Strategy.

The four main principles that underpin the North West London system reconfiguration shape our Clinical Strategy:

- **Localisation** will mean patients have better access to routine medical services closer to home with improved patient experiences
- **Centralisation** of most specialist services will mean better clinical outcomes and safer services for patients
- Where possible, there should be **integration between primary and secondary care**, with involvement from social care to give patients a fully co-ordinated service
- The system will look and feel **personalise**d to patients – empowering and supporting people to live longer and live well

3.1.1 Integrated Care

For care to be integrated it must be person-centred, coordinated and tailored to the needs and preferences of the individual, carer or family (NHS England, 2013). The NW London Sector has pioneered the development of integrated care models. We plan to use the experience and commitment within the sector to transform care for patients with multiple and complex needs which span health, social and voluntary sectors. With partners we will co-design an evidence-based model of care to reduce hospital admissions, achieve shorter length of stay where admission is unavoidable and reduce unplanned readmissions to hospital. Where possible this care will be delivered in the community setting with multi-agency and multi-professional teams. New pathways will improve the quality of care and use of resources for those living with long term conditions.

NHSE recommends co-located urgent/primary care models. The benefit of co-location with the Emergency Department is the reduction of waits and improved flows through Emergency Departments by allowing staff in the main department to focus on patients with more complex conditions. We currently manage or work with our partners to provide Unscheduled Care Centres (UCCs) at our three main sites. In addition, we are in the process of expanding the Ambulatory Emergency Care Units on our two main acute sites to increase the available alternatives to hospital admission and facilitate early hospital discharge as appropriate.

3.1.2 Personalised Medicine

Our plans for personalised medicine are to target and tailor the treatments that are the most effective at an individual level using the analysis of genomes and phenotypes which enable the identification of those at risk of particular diseases. We will develop resources and capabilities to undertake detailed characterisation on a large scale. To realise this we will establish capacity and capabilities in phenotyping, genotyping and imaging and develop pathways to support the adaption

of these techniques in routine clinical practice. We are one of the UK's designated eleven Genomics Medical Centre with our partners C&W, RBH and RMH.

We are making progress in implementing our clinical strategy with initiatives that are delivering direct and immediate benefits for patients, described below:

3.1.3 Sector-wide Improvements
The sector-wide principles have started to be implemented with the closure of the Maternity Unit at Ealing Hospital with deliveries being transferred to the surrounding hospitals, thus enhancing critical mass and Consultant-delivered care, whilst maintaining ante- and post-natal care close to home. Additionally, the Paediatric In-patient facility at Ealing Hospital has closed with in-patient care being centralised in fewer hospitals and thereby starting to optimise access to senior decision makers.

3.1.4 Acute Medical Services
The Deputy Medical Director leads the implementation of the Clinical Strategy and Phase One of the Programme has recently completed with the rationalisation of Acute Medical Services from three sites down to two, thus enhancing access to senior decision makers, both in the Emergency department and in the Acute Medical Units, and moving towards more resilient rotas. A new Chest Pain Pathway has been developed to allow patients with cardiac chest pain to access specialist opinions much earlier thus moving towards the ideal of 'right clinician, right place, first time'.

3.1.5 Ambulatory Care
A comprehensive review of Ambulatory Care has been performed with a resulting expansion in staff, facilities and hours of operation thus reducing pressure on the Emergency Departments, providing alternatives to non-elective admission and facilitating early discharge. Phase Two of the Programme has been designed with and is being jointly undertaken with the Quality Improvement Team to allow the sharing of skill sets and resources. This has just commenced and will focus on 'in-patient flow' through the system. The work streams will initially concentrate on the management of the frail, elderly patient and on the development of an ideal Ward / Board Round model. During 2016/17 the implementation programme will be reviewed to ensure it remains aligned with Trust priorities and productivity and improvement opportunities. We consolidate our stroke services onto the Charing Cross site in 2014/15 to bring our clinical expertise into a single service offering along the stroke pathway.

3.1.6 Improving Our Out Patient Experience
A coordinated, overarching Outpatient Improvement Programme was developed with activities aligned to the issues identified by the CQC and subsequent must-do compliance actions. Delivery of the improvement is through six defined work streams: clinic capacity & eReferrals, registration and scheduling, right first time, clinic management, clinic environment, GP and patient communication. Progress is being made against key milestones: The Patient Service Centre was approved at Trust Board with a £7.2m grant agreed with the Imperial College Healthcare Charity. New customer care training was rolled out in 2015/2016. QI projects have been scoped around two areas of focus; central booking office processes and health record management. All new referrals processed by the Central Booking Office are now being scanned and saved on to the Clinical Document Library (CDL) reducing reliance on the availability of a paper record and improving access to clinical information.

We are an acute provider early adopter of the health and wellness initiative 'Making Every Contact Count', in partnership with Public Health colleagues. We are piloting a large-scale training programme for outpatient staff at the St Mary's site, from October 2016, to support staff in helping patients in developing behavioural strategies for healthy living. We intend to apply the learning from this work to all further training across our sites.

3.1.7 Developing Models of Care for Integrated Care and Out of Hospital Care

As part of the recent management restructure, we established the Directorate of Integrated Care within the Division of Medicine and Integrated Care. There has been investment in a new senior managerial and clinical team that now holds Trust-wide responsibility for developing the Trust's integrated care strategy and for supporting operational teams in qualifying, bidding for and mobilising new community or integrated services. The operational remit of the new directorate provides increased focus on relationships with local providers of primary care, community care, mental health, voluntary sector and social services with a view to minimising unnecessary time spent in acute care for patients.

3.1.8 Accountable Care Partnership

There are significant opportunities for us to work more closely with our partners to reduce the three gaps set out in the FYFV to improve the care we provide to patients and to play out part in developing an effective health system across our STP footprint.

Together with C&W we signed a Memorandum of Understanding (MOU) with the Hammersmith & Fulham (H&F) GP Federation and West London Mental Health NHS Trust in June 2016. The MOU sets out our shared intention to work towards the establishment of an Accountable Care Partnership (ACP) to manage the health and wellbeing of the population of H&F under a capitated payment system from April 2018, in line with local commissioning intentions.

An ACP is a variation of an Accountable Care Organisation (ACO) which brings together partners to take responsibility for cost and quality of care for a defined population within an agreed budget (Kings Fund, 2016). ACOs exist along a spectrum of integration from fully integrated systems to alliances and specific clinical networks.

Learning from international ACOs and the early experiences of NHS vanguards, has helped us to develop the ethos in developing our ACP, these include: A clear focus on **Better Health for Life** to address the health and wellbeing gap, building strong relationships across all partners, clinical leadership throughout all our plans , digital capabilities to support case management and self-care using effective information exchange between all health providers and patients, commissioning and payment structures that support an outcome focused, integrated service.

We are co-designing the principles to underpin our ACP operating model. The CCGs of Central London, Hounslow, Hammersmith & Fulham, West London and Ealing (CHHWE) have adopted the ACP Maturity Assessment Framework. We will develop our ACP core operating model to address the key domains of the Framework that are within the control of provider partners. We will explore new models of care as set out in the FYFV, in particular the benefits and risks of a Primary and Acute Care System (PACS). PACS care models operate at four levels of population need: whole population – prevention and population health management, urgent care needs, on-going care needs - enhanced primary and community care with more services in the home and community setting; and highest care needs – coordinated community-based and inpatient care for the management of complex conditions.

The commissioning intentions from the NW London CCGs for 2017/18 set out an ambition to focus initially on an ACP based on the 65 years and over population.

3.2 Quality Strategy

Approved by the Board in July 2015, our Quality Strategy is built around the five quality domains: Safe, effective, caring, responsive and well led, that provide our definition of quality (CQC, 2014). It is designed using best practice principles from national reports and inquiries, coupled with local

learning from surveys, data analysis, adverse events and feedback from key stakeholders. The Quality Strategy focuses on our priority areas for improvement and how we will address areas that were highlighted in our CQC inspection. Implementation of the strategy is supported by a series of comprehensive quality goals and targets for each domain.

Goal 1. To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm. We believe harm is preventable not inevitable
Goal 2. To show continuous improvement in national clinical audits with no negative outcomes
Goal 3. To provide our patients with the best possible experience by increasing the % of inpatients who would recommend our Trust to friends and family if they needed similar care or treatment to 95%, and 85% for A&E patients
Goal 4. To consistently meet all national access standards by the end of year three of the quality strategy
Goal 5. To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis

During 2015/16 we made progress in delivering on our Quality Strategy under each of the goals (G), key examples are presented below with a summary of areas of future focus:

G1. We reduced the number of incidents causing severe or extreme harm and reduced grade 3 pressure ulcers developed in hospital by 42%, reported no grade 4 pressure ulcers, achieved 96% harm free care as measured by the Safety Thermometer, routinely assessed over 95% of patients for risk of VTE, met planned safe staffing levels, exceeded our target of shifts filled by registered nurses, midwives and care staff. We launched the 'Safe Steps' campaign to promote safer mobility and continued to deliver our 'Sign up To Safety' improvement plan. We are focusing on reducing 'Never Events' supported by continuing to develop our safety culture, improve surgical safety, and minimise the risk of hospital acquired infection.

G2. We reported mortality rates consistently among the lowest in the country; developed a new online mortality review system to evaluate every death occurring in the Trust to quickly identify any potential issues and learn from them; implemented a process of robust feasibility assessments for all clinical trials and introduced a robust system for nurse revalidation to ensure they are up to date and fit to practice. We are working to improve surgical outcomes as measured by PROMs and the timeliness of discharge.

G3. We saw an increase in the number of inpatients and A&E patients who would recommend the Trust as a place for treatment; We changed our systems for collecting patient experience feedback to enable us to reach more diverse patient groups, restructured our complaints service , reduced the overall number of complaints received and responded to 100% of complaints within the timeframe agreed by March 2016; we focused on improving the experience of patients with learning disabilities and the achievement of registration as a Makaton friendly trust, we consistently exceeded national standards relating to finding and assessing, investigating and referring patients with dementia; restructured and increased the number of cancer clinical nurse specialists and introduced a new support navigator team in partnership with Macmillan Cancer Support; and introduced Schwartz Rounds. An area of focus going forwards is working to improve our Friends and Family Test (FFT) response rates.

G4. We reduced unplanned readmission rates, now below national average; expanded ambulatory emergency care services at St Mary's and Charing Cross sites, resulting in more patients being treated and discharged the same day, developed improved patient pathways and implemented an outpatient improvement programme. An area of significant improvement work is in progress to

support an improvement trajectory to achieve the national access standards, reduce the number of patients waiting 52 weeks for treatment and improve our results in the National Patient Led Assessment of the Care Environment (PLACE)

G5.We exceeded our target to reduce sickness absence and introduced a range of health and wellbeing initiatives for staff; improved the experience of our junior doctors and medical students through our education transformation programme, resulting in an improvement in student feedback and the reintroduction of training in neurosurgery and ophthalmology, where it had previously been suspended, we launched our new values and behaviours and our QI programme which provides training and support for staff. We are focusing on reducing voluntary turnover and increasing compliance with statutory and mandatory training.

3.2.1 QI Programme

We launched our QI programme in September 2015 alongside our new Trust values & behaviours, which are central to the programme. The QI programme aims to build a culture of continuous improvement within the Trust.

The programme is underpinned by four key objectives:

- Build capacity and capability through a programme of QI education and training to enable staff to lead QI activities and initiatives within their teams.
- Engage with staff and patients to ensure everyone knows about QI and feels empowered to get involved in improving care.
- Develop a cohort of QI Champions across the organisation who have the leadership capacity and capability to enable others to get involved in QI.
- Support teams to deliver QI projects and programmes which are co-designed with patients, service-users and the public.

Over the past year we have engaged with over 6,500 staff around QI, initiated a broad ranging training & coaching programme and are supporting quality improvement projects to design and implement team-based tests of change. We will continue to transform our approach to patient, public, citizen and carer involvement and how we collaboratively approach system wide change.

3.2.2 Care Quality Commission (CQC) Inspection

The CQCs 2015/216 Report, State of Care, highlights that for all core services rated across NHS Trusts 5% are inadequate, 39% require improvement and 51% are rated as good.

The Trust has not been inspected by the CQC since the Trust-wide inspection of all services in September 2014, after which the CQC awarded us an overall rating of 'Requires improvement' (with 'Good' overall for the 'Caring' and 'Effective' domains). An improvement and assurance framework was developed in response to the inspection findings and is a component of our 2015-2018 Quality Strategy.

Our compliance and assurance framework sets out the approach to assess and monitor compliance with the CQC's regulations and to support the delivery of 'good' and 'outstanding' care. It consists of a range of activities including checks that our services are correctly registered, quality reviews based on the CQC's inspection methodology, and divisional self-assessments against the CQC domains. Additionally, an annual ward accreditation programme was implemented from 2014/15 which is aligned with the CQC domains and ratings categories. The framework also includes preparations for and management of future CQC inspections.

Following on from the compliance and core service reviews and deep dives carried out as part of the improvement and assurance framework during 2015/16, it was decided that for 2016/17, quality reviews would be carried out on request from an area or in response to concerns being raised about an area. Between February and September 2016, four quality reviews were carried out: two on request from an area and two in preparation for the upcoming re-inspection of the Outpatients and diagnostic imaging services at the Trust (scheduled for November 2016). In our ward accreditation programme, at the end of September 2016, 56 inpatient ward accreditations had been completed with a further 19 scheduled for completion by the end of October 2016. The ward accreditations of main outpatient areas were expanded into the core service reviews referred to above.

3.3 Redevelopment Programme

Our estates redevelopment programme enables the implementation of our Clinical and Quality Strategies, fully supports and is aligned with the NW London local health economy transformation plans which take a whole systems approach in changing the way local healthcare is delivered and in breaking down organisational boundaries between primary and secondary care.

The redevelopment programme involves a significant refurbishment, reconfiguration and new builds of the main hospital sites within the Trust's estate. Affordability of the scheme, agreement of the plans and support from the local communities are vitally important factors in determining the success of the programme. To achieve the full benefits realisation of the scheme we have been careful to learn lessons from the Paddington Health Campus scheme, implemented a programme governance framework, established operational work streams including communications and engagement and tendered for expert commercial and technical advisors.

3.3.1 Site Plans

The sector-wide transformational change, which supports whole systems care will provide each of our main sites with a clear identity, a sustainable future and will enable us to provide care in fit for purpose facilities and improve efficiency in the use of our buildings and provide a better patient and staff experience.

- **St Mary's,** with a co-located **Western Eye Hospital**, being the major acute and trauma centre for the area
- **Hammersmith and Queen Charlotte's & Chelsea** extending their roles as a specialist hospital
- **Charing Cross** evolving to become a new type of pioneering local hospital, with planned, integrated and rehabilitation care

As part of our strategy to achieve a major step change in the quality and sustainability of our services, we are progressing an opportunity to bring forward a first phase of the redevelopment of St Mary's Hospital. The phase 1 redevelopment would see the creation of a brand new building on the eastern side of the estate - currently Salton House and the Victoria and Albert and Dumbell buildings.

The first phase, the new outpatients building would be a modern, flexible and welcoming environment for planned diagnostics and consultations, bringing together the majority of our current St Mary's adults and paediatrics outpatient clinics – currently provided from 40 different locations - including the Jefferiss wing, the Winston Churchill building, the main outpatients clinic and a part of the Mary Stanford building. The phase one redevelopment is an important first step and is clearly mindful of the next phases to come.

Our wider estates redevelopment proposals across all of our sites have always been premised on the need for us to fund them from the value of our surplus land as far as possible. Proposals for the whole site redevelopment of St Mary's Hospital are being incorporated in a strategic outline business case for capital investment for the NHS across NW London, led by our commissioners.

3.3.2 Transport and Travel

Nationally transport and related issues feature prominently in issues raised by stakeholders. Our Transport Strategy Working Party, comprising a wide range of stakeholders including Transport for London (TfL), London Ambulance Service (LAS), local authorities, branches of NW London Healthwatch, SahF and Trust staff are working together to review and re-design our policies in all aspects of travel and transport. Detailed travel surveys across all main sites were completed during late 2015 and the results used in developing a site specific travel plan for the proposed redevelopment at the St Mary's site.

Our stakeholder group meets quarterly and will continue to champion better travel for our patients, staff and public. During 2016/17 we will focus on developing travel plans to support the redevelopment programme and a car parking policy.

3.4 Estates Strategy

Our Estates Strategy was approved by the Trust board in July 2016. This document provides an integrated approach to the estate based on Trust Clinical Strategy and supports our Trust position to consolidate our place as secondary care provider of choice in NW London. The aim of the strategy is to ensure that we provide safe, secure, high quality healthcare buildings capable of supporting current and future healthcare needs and seeks to make significant reductions in legacy estate.

The strategy includes a comprehensive review of backlog maintenance and shows the level of risk at each of our main sites and the overall condition of our estate. During late 2016 we have been reviewing the findings of external reports into our backlog maintenance and developing options for Board discussion on how we might best address our high risk backlog requirements in the short to medium term and longer term – through a redevelopment programme. It is essential that we have a quality assured approach to managing the risks associated with deferring aspects of backlog so that we continue to provide a safe environment for patients, staff and the public. We will continue to further develop options, re-profile our capital programme and review how we approve capital requests and ensure that we continuously seek to maintain progress in managing all associated risks.

3.5 Our Financial Plans

Our strategic finance plans take an integrated approach to quality improvement, clinical transformation and financial sustainability, recognising that all three elements are critical to our ability to transform our organisation to deliver our promise: **Better Health for Life.**

The need to make savings is driving a phase of rapid innovation and we are actively exploring how we can play our part in this. We are responding to the financial challenges in a number of ways:

- Actively engaging in the NWL STP to focus on the health of the local population including new models of delivering services, integrated care, as well as reducing duplication and inefficiencies, back-office consolidation
- Our Financial Improvement Programme to deliver the cost improvements necessary to return the trust to financial sustainability. This includes establishing a new central Project Support Office, and 'cost control trios' in each clinical and corporate division, as part of a long term response to driving down costs. In addition we have commissioned a financial

review to understand the causes of our deficit with the identification of targeted improvements
- Exploring opportunities to rationalise services, including with partners across NW London.
- Understanding the profitability of our clinical services and their potential for transformation through comprehensive service line reviews

3.5.1 Lord Carter's Review of Provider Productivity

Lord Carter's Review of Provider Productivity identified potential savings for the Trust and work has commenced to validate the projections and to develop detailed plans. These include developing a single version of benchmarking for costs to understand what good looks like known as 'the model hospital', a national people strategy to support transformational change, analysing worker deployment with plans for each trust to undergo a pharmacy transformation programme and plans to improve the cost and quality of diagnostic services both by April 2017, commitment to the NHS Procurement Transformation Programme realising a reduction of 10% in non-pay costs by April 2018, space utilisation targets for the estate with plans to be implemented by April 2017 and delivered by April 2020, delivering savings in the cost of corporate and administrative functions with costs at no more than 7% of trust income by April 2018 and 6% by 2020, standards of best practice for all specialities to assess clinical variation along a pathway, key digital information systems fully integrated and utilised by October 2018, supported early discharge initiatives and plans for step down care, and finally, an integrated performance framework to reduce the burden of multiple reporting requirements by July 2016. Trusts are required to have local plans in place to timescales set out in the report.

Going forward our plans to maximise efficiencies through this programme of work include: Pursue recommendations put forward with regard to medicines with savings opportunities and monitor the monthly list of 'Top 10 Medicines with Savings Opportunities' to identify any potential savings. In addition we will implement a strategic estates and facilities plan, including a cost reduction plan for 2016-17 based on the benchmarks, and a plan for investment and reconfiguration where appropriate.

3.5.2 North West London Pathology

NW London Pathology is a joint venture between three NW London providers:
- Imperial College Healthcare NHS Trust (ICH)
- Chelsea and Westminster NHS Foundation Trust
- The Hillingdon Hospitals NHS Foundation Trust

Configuration as a hub and spoke model, with a large centralised hub for routine work, plus smaller 24-hour 'hot lab' spokes at each site for the most urgent work, it provides a full range of services for the three Trusts. The new service, hosted by the Trust, acts as an 'arm's length' trading entity with a distinct management structure and set of trading accounts. The consolidation of these services and staff expertise is assumed to realise significant savings for its member organisations and to provide an excellent patient and referrer experience.

3.6 People and Organisational Development Strategy

Our People and Organisational Development (P&OD) strategy was approved by the Board in June 2016. It is centred on eight strategic themes which respond to the workforce challenges highlighted in recent policy directives such as the FYFV (DH, 2014), in particular the finance and efficacy gap in building a sustainable high quality workforce. Delivering excellent patient care and quality is at the centre of the strategy to ensure our workforce is skilled and able to adapt to delivering new models of care. Our organisation design devolves accountability to deliver these aims, providing an engaged, empowered and dynamic workforce. The themes are as follows:

- **Strategic workforce design –** planning a workforce that will meet our current and future healthcare needs supported by the Workforce Transformation Committee
- **Resourcing –** Attracting and retaining talented people at all levels from within and outside the Trust, aligned to the diverse needs of our population
- **Building capability –** developing, providing real career opportunities and building talent pipelines so that we are a leader in education and training.
- **Talent and organisation development** – Focusing on pro-active talent management to attract, develop and importantly retain our staff and supporting them to live our organisational values
- **Engagement and culture change –** developing a culture reflective of our values; a culture of continuous improvement and being seen as an 'Employer of Choice'
- **Employee relations and Reward** – developing positive partnership arrangements with staff side and Trade Unions and a successful employee relations advisory service, focus on developing our approaches to equality and diversity and place a greater emphasis on developing our 'total reward' offering
- **Promoting health, wellbeing and safety –** Advocating the importance of healthy and safe hospitals for patients, staff and others with policies and practices that support health, wellbeing and safety in the workplace.
- **Building efficient infrastructure** –building scalable and efficient infrastructure with P&OD systems and processes that are up to date and 'fit for purpose'

Key achievements during 2015/16 include establishing the new organisation design which became live in April 2016, establishing the Workforce Transformation Committee that will oversee the development of a workforce plan built up from directorate level strategic planning, succeeding in rolling out healthcare rostering to support better use of workforce resources, implementing a new annual local staff engagement survey which more comprehensively measures staff views on working at the Trust. This survey was run in August 16 with a 38% response rate across the Trust, the results have seen an improvement in overall engagement. Our performance in attendance at mandatory training continues to increase and is slightly above London peer average at 87.2%. Additionally we remain on target to achieve the agency reduction target in 206/17, and are focused on achieving the Carter recommendations for staffing costs.

3.7 Informatics Strategy

Our strategy for ICT was approved by the Board in December 2014 and is an essential enabler across all our strategic plans. The FYFV places emphasis on the importance of exploiting the information revolution and is supported by Personalised Health and Care 2020, A Framework for Action by the National Information Board (2014).

Our plans set out the vision, skills and tools to get 'the right information to the right person at the right time to improve healthcare and promote health'. Our information principles stem from the vision that we are patient centred, digital by default, safe and secure, structured and standards based, captured once for multiple purposes, accessible and high quality data.

The strategy has five strategic objectives:

- Develop a consolidated digital patient record inside the organisation and the infrastructure needed to support digital by default for our clinicians
- Have the ability to share digital patent records with other care providers
- Empower patients to take an active role in their care through access to a composite digital patient record through the use of digital media

- Develop the systems so that it is possible to co-ordinate and manage complex patient pathways across multiple providers
- Support Population health

Our primary focus is the clinical systems and infrastructure necessary to meet clinical needs. In addition the strategy supports the effective prioritisation of investment decisions as part of the annual business planning process and the capital programme. It consists of three components:

i). The Digital Patient Record
Our Cerner roadmap outlines the key milestones to implementing the digital patient roadmap. Building on a successful launch in maternity services in 2014/15, we rolled out a patient administration system (PAS) in 2014/15 and clinical documentation (Clin documents) and electronic prescribing during 2015/16 The digital record provides opportunities to link to GP specific systems which are vitality importance for out of hospital services.

ii). A Shared Patient Record
We are working increasingly in the community, with new community-based systems being introduced to share information with GPs and manage out of hospital care. More widely, the Trust is leading work in NW London to create a comprehensive, aggregated patient electronic record that will be accessible across health and social care providers and to patients and their carers to improve patient engagement and self-management.

ii). Digital by Default
To address the problem of residual paper–based practices we will move to producing documents that are capable of an electronic format at the point of creation, we will share documents by storing them in a single, accessible location or integrated to the EPR. An electronic distribution mechanism will be introduced to ensure documents are readily available at the point of care.

During 2016 we made significant progress in implementing our ICT strategy. A key achievement was being recognised by the DH as a Global Digital Exemplar, with our partner C&W, in October 2016.

With the appointment of our Chief Information Officer (CIO) as the joint CIO with C&W across two our organisations from 1st October 2016 our aim is to develop a single shared electronic record across both Trusts in order to provide patients with better care and experience and to share learning and best practice.

We completed a Trustwide implementation of the electronic patient record across all specialities and are working to phase out the paper record system that we maintained as risk mitigation during the initial implementation. In addition we have linked up our electronic records with SystemOne, the records system used by our local GPs.

We continue to develop the NW London Care information Exchange, which we host, and which allows patients and professionals to share information in a secure environment. We are in the early stages of the system going live with patients. This initiative, which is supported by funding from our charity, is viewed as an important theme in the digital enabling work programme in our STP.

With our electronic patient record, growing digital expertise and close partnership with Imperial College we are rapidly developing capabilities to analyse population health data to use this intelligence into our planning processes and in particular our developing plans for an ACP.

3.8 Academic Health Science Centre Strategy

We were designated as one of the UKs six AHSCs by the Department of Health in 2014.

The AHSC mission is to accelerate the translation of scientific discoveries into medical advances, new therapies and techniques, in as fast a timeframe as is possible so that the quality of life of our patients and populations is measurably improved.

We aim to make advances in the prevention, diagnosis and treatment of disease, both common diseases with large societal burdens and rare conditions afflicting individuals and families. The overarching strategy of the AHSC is to:

- Integrate the research strengths across all Imperial College London faculties with the critical mass and clinical expertise of the NHS partner organisations;
- Create powerful new interdisciplinary synergies through translational science, bioengineering and informatics;
- Educate and train the future generation of scientists capable of developing and utilising new interventions for enhanced healthcare;
- Translating research into healthcare practice and policy for the benefit of patients nationally and internationally
- Creating new wealth through innovation in healthcare, discovery science and population-based translation

In June 2016, the RMH and the RBHH became members of our Imperial College AHSC. The expanded AHSC membership provides additional opportunities to align strategies around education, research and clinical care.

The engine of our AHSC is the NIHR Imperial BRC. Our BRC supports translational research, taking the findings from basic laboratory research more quickly and efficiently into medical practice in a clinical setting, thereby delivering improved health outcomes for our patients. It funds clinical academics, clinical research infrastructure and projects to create a pipeline of discovery science pulled through into later phase clinical trials in world class clinical research environment.

With Imperial College we successfully renewed NIHR BRC funding during 2016 with a £90m award to cover the period 2017-2022. The new award will focus on eight scientific themes that reflect both the College's academic strengths and align with the clinical expertise in the Trust and challenges faced by the NHS:

- Brain Sciences
- Cancer
- Cardiovascular
- Gut Health
- Infection
- Immunology
- Metabolic Medicine & Endocrinology
- Surgery & Technology

Our research strategy also includes involvement and engagement of patients and the public in the design, implementation and review of our research to ensure maximal patient benefit.

3.9 Education Strategy

Our AHSC established a Clinical Academic Training Office (CATO) in May 2015 to support the shared clinical academic objectives of the College and the Trust. CATO provides a comprehensive signposting and support service for medical and non-medical clinical staff interested in an academic career. Through CATO, we provide a vibrant and nationally leading clinical PhD programme for doctors. We have also pioneered, in partnership with the NIHR Imperial BRC and Imperial College Healthcare Charity, new fellowship opportunities to support non-medical staff to pursue NIHR programmes at PhD and post-doctoral level.

Our multi-professional Trust Education Strategy was approved by the Board in June 2016. Our education strategy sets out how we will support the delivery of the Clinical Strategy, local and national developments in healthcare and our values through the delivery of world-class education and training. It focuses on five strategic themes: skills and knowledge, new models of education and training, multi-professional education, technology for learning and supporting research and development.

In the first three months of the strategy going live we have focused on promoting the key performance indicators at the Trust Education Committee and have been working closely with the Director of P&OD in developing the workforce transformation plan for the Trust to support new ways of working with new roles for staff and their associated education and training needs.

3.10 Patient and Public Involvement Strategy

The Patient and Public Involvement (PPI) Strategy was approved by the board in July 2016. The five-year plan set out the four key areas for PPI development as outlined below.

Figure 5. Organisational Framework for Patient and Public Involvement

The strategy also outlines goals under four work streams:

- PPI infrastructure – development of processes, resources and policies to support and enable Trust involvement activity. For example a PPI expenses policy, a PPI toolkit and training for Trust staff.
- Raising awareness and engagement – within five years, the Trust will be seen as a leading organisation in terms of the positive impact of our PPI approach.
- Systematically acting on feedback – insights and learning from our involvement work will be systemically reviewed and acted on. It will be analysed and used alongside our existing

patient feedback mechanisms such as the Friends and Family Test and patient surveys to ensure the Trust is listening to patients and collaboratively working with our communities.

- Patient ownership of health and wellbeing – within five years, we want the vast majority of patients with on-going health conditions to be engaged with us in maximising their own health and wellbeing or have taken steps to become experts in their own care. Many projects underway already support this, such as having access to your own medical records via the Care Information Exchange.

3.11 Private Healthcare Strategy

We are an established provider of private healthcare at each of our main sites, through Imperial Private Healthcare (IPH). IPH makes a significant financial contribution to our operating cost, with all profits being reinvested to improve our Trust NHS clinical care.

The London private healthcare market is competitive and well subscribed with a number of private provider chains dominating the market. Growth in market share relies on securing consultant support to establish referral pathways and providing a wide portfolio of general and specialist services.

Our private healthcare vision is to:

- Maintain income growth in the short term using the existing capacity and improve essential infrastructure such as financial reporting systems
- Stretch targets for income generation which are supported by a plans to encourage our consultants to carry out their private practice on site and reward divisions for this work
- We will develop new clinical service offerings in the mid-term such as a paediatrics service at the St Mary's site and haematology at the Hammersmith site
- To facilitate growth in the UK market we will seek to increase our offering of specialist surgery, oncology, gastroenterology, trauma and orthopaedics and urology
- For overseas growth the most popular services are similar and also include plastics, reconstructive surgery, acute renal services and neurosciences. Many of these services are high performing ones at the Trust
- In the longer term we will explore the opportunities to build an expanded co-located private hospital as part of the redevelopment programme at the St Mary's site, and explore potential partnerships
- As part of developing plans for extra capacity we will explore smaller schemes as intermediate solutions, including ring-fenced diagnostics to support a more streamlined patient experience
- Develop our operating model - IHP has well developed relationships with several international providers and through these links helps to raises our overall Trust profile overseas, helping to support our plans to direct international clinical students to educational opportunities at our sites and inbound health tourism

With the appointment of a new Director for Private Healthcare, commencing at the Trust in November 2016 we will continue the implementation of our strategy.

3.12 Review of the Organisational Strategy

We will develop an annual business plan to progress the implementation of our organisational strategy. We will also continue to review progress against the individual plans within this organisational strategy annually and share our progress publically.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

CQC Quarterly Update: Quarter 2, 2016/17

Executive summary:

During quarter 2 (Q2), 2016/17:

- The Trust made 19 applications under the deprivation of liberties safeguards.
- No patients died whilst being detained by the Trust under the Mental Health Act 1983.
- No certified treatment was sought or delivered for Trust patients.
- There were six concerns that the CQC requested the Trust investigate in Q2.
- The Trust was not inspected by the CQC in Q2.

Quality impact:

The report applies to all five CQC domains.

Financial impact:

This paper has no financial impact at present

Risk impact:

This paper relates to the following risks on the corporate risk register:

- **Risk 81:** *Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target*
- **Risk 87:** *Failure to deliver outpatient improvement plan*

Recommendation to the Trust board:

The Trust board is asked to note the paper

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion

Authors	Responsible executive director	Date submitted
Guy Young, Deputy Director of Patient Experience Kara Firth, Regulation Manager	Janice Sigsworth, Director of Nursing	22 November 2016

CQC Quarterly Update: Quarter 2, 2016/17

1. Purpose

The following report is the regular quarterly report to this Committee providing an update in relation to the Trust's CQC registration. This report covers quarter 2 (Q2) of 2016/17.

2. Registration Status

The Trust continues to be registered at all sites without any conditions.

3. Notifications made to the CQC

3.1. Mental health notifications

- In the best interests of patients and to support the safety and quality of care, 19 following applications were made to deprive patients of their liberties (DoLS) in Q2.
- No patient deaths took place whilst being detained under the Mental Health Act in Q2.
- No certified treatment was sought or delivered in Q2 (i.e. by a panel or second opinion appointed doctors (SOAD)).

4. Contact with the CQC (concerns and complaints)

- The CQC asked the Trust to investigate six concerns in Q2, which were raised directly with the CQC. Please refer to **Appendix 1** for a summary of these.
- No whistleblowing alerts were made to the CQC about the Trust in Q2.

5. CQC Inspections and Reviews

5.1. Inspections

- The Trust was not inspected by the CQC in Q2
- On 1 July 2016, the Trust received notification of a re-inspection of the core service of *Outpatients and diagnostic imaging*
    - The announced site visit scheduled for 22 to 24 November 2016 (Q3)
    - Inspection preparations are reported monthly at the Executive Transformation Committee, alongside updates on the Outpatient Improvement Programme.

5.2. CQC Reviews

The Trust did not participate in any national or thematic reviews carried out by the CQC during Q2.

6. Compliance with Legislation and Standards

6.1. NHS Accessible Information Standard

- The committee will remember from its meeting on 2 August 2016 that the Trust was working to become fully compliant with the new NHS Accessible Information Standard, which became a required on 31 July 2016
- The Trust is not yet fully compliant with the standard:
    - Cerner have developed a solution that will enable Trusts to meet the requirements relating to flags in electronic records. This is currently being piloted at another London trust prior to further roll-out.
    - Work with Cerner is also on-going to auto-generate patient letters in an accessible format.
    - While the Trust works towards being fully compliant with the standard, flags are being made in medical records.
- Staff can link with the Patient Experience team for support in any individual case where accessible information is needed but not yet available.

Recommendations the Board

To note the paper.

Appendix 1: Summary of concerns about the Trust raised by the CQC during Q2 2016/17

Site	Division	Concern	Status
SMH	WCCS	• Poor care during labour and delivery • The serious investigation concluded that the clinical care received was adequate • The parents' had a range of concerns about the practice and behaviour of nurses and midwives • No formal complaint was made to the Trust; the parents went only to the CQC	• In response to the concerns raised, a lessons learned action plan was developed • **The CQC do not consider this matter closed as a new procedure for transfer of babies to the mortuary is pending**
SMH	MIC	• Potential for unsafe discharge due to lack of appropriate accommodation, in relation to an infection control matter • The CQC asked for assurance from the Trust that its discharge process has adequate safeguards to ensure the patient is not discharged if their accommodation would make them clinically unsafe	• The patient remains in hospital at present and discharge has not been planned at this time • **The CQC do not consider this matter closed as the patient's discharge is pending**
CXH		• An allegation of poor end of life care • The patient's partner contacted the CQC and made a formal complaint to the Trust	• The concerns about staff practice and behaviour were deemed legitimate and an action plan was developed to address these • **The CQC consider this matter closed**
HH		Trust-acquired pressure ulcers due to inappropriate / inadequate care	• The patient was known to be high risk for pressure ulcers; the patient's records show that care was appropriate and all appropriate efforts were made to prevent pressure ulcers • **This remains open as the serious incident investigation is on-going**
Trust-wide		• During the first six months of 2016, five separate allegations of unsuitable discharge practices and mismanagement of the Trust's discharge team were made to the CQC • Rather than request a separate review into each concern, the CQC requested a review of the team's structure and operation, to determine whether there are any concerns which might substantiate the allegations	• The review was carried out by a senior health professional external to the division o No incidents during the review period were attributed to the practice of the discharge team o Improvements were made in response to complaints about the discharge team o No concerns with recruitment or management of discharge team members were identified • **The remains open as the Trust's response was submitted to the CQC mid-October and no reply has been received**
		• Failure to initiate a safeguarding alert at a patient's request was based on: o Lack of supporting information being provided by the patient o Lack of awareness of the Trust's legal remit in cases where patient's make such a request	• The safeguarding alert was raised on behalf of the patient when legal clarification was made that the Trust can do this (Care Act 2014) • **The CQC consider this matter closed**

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board	30 November 2016

North West London Sustainability and Transformation Plan

Executive summary:

Introduction

Sustainability and Transformation Plans (STPs) are 'place based', five-year plans built around the needs of local populations and which support the implementation of NHS England's (NHSE) Five Year Forward View (FYFV) by addressing the three gaps in health and wellbeing, care and quality, finance and efficiency.

STPs are important as they describe the strategic direction agreed by partners across a geographical footprint to develop high quality sustainable health and care and will determine access to the NHS Sustainability and Transformation Fund (STF) which will total £3.4bn by 2020/21. In addition the new Single Oversight Framework from NHS Improvement (NHSI), designed to help NHS providers achieve Care Quality Commission ratings of 'Good' or 'Outstanding', includes STP milestones progression in its assessment criteria.

A 'checkpoint' submission of the draft version of the STP was submitted to NHS England (NHSE) and NHSI on 30 June 2016. Feedback on this submission from NHSE and NHSI, as well as feedback arising from north west London (NWL) stakeholder engagement events and comments from health and social care partners helped shape the STP which was submitted on 21 October 2016.

This paper comprises two sections: Firstly it presents a review of key changes from the June draft submission and the content of the STP submitted in October; secondly it summarises and recaps the strategic themes in the October STP. Appendix one presents the NWL STP October submission and appendix two is the October submission appendices.

1. Key Changes between NWL STP June and October 2016 Submissions

1.1 Joint Statement from the NWL Boroughs

Six of the eight NWL boroughs signed the joint statement on Health and Care Collaboration in NWL in the June and October submissions, this excludes Ealing and Hammersmith and Fulham

1.2 Delivery Areas (DA)

The NWL STP nine priorities and DAs remain unchanged. Small revisions were made to the DA individual plans and their key deliverables:

DA1 Additional actions include developing a number of cross cutting approaches, embedding Making Every Contact Count and supporting national campaigns

DA2 Plan addition of 'a. Delivering the Strategic Commissioning Framework and Five Year Forward View (FYFV) for primary care', improving cancer screening actions were updated to include working 'in partnership with Healthy London Partnership' s Transforming Cancer Programme' and the Royal Marsden Partners Cancer Vanguard

DA3 c. Implement new models of local services integrated care to consistent outcomes and standards was removed. Additional actions were included for older peoples services

DA4 b. 'Focussed interventions for target populations' replaced 'Addressing wider determinants of health'; the target population for mental health and related conditions was increased to 482,700.
DA5 c. Addition of 'fully delivering on Better Births national maternity review' and inclusion of Safer Staffing with a 'three year delivery plan and agreement on investment identified' in 2016/17 and by 2020/21 a 'workforce plan for NWL and collaborative resourcing'.

1.3 Primary Care
A more detailed section on primary care in the context of out of hospital services and intermediate care transformation was included in the October STP.

1.4 Enablers
Estates Addition of **'**a joint One Public Estate bid' to be explored as an early devolution opportunity. A joint Health and Estates Council has been established. Further details were included on 'Deliver Local Services Hubs' including mental health services and to provide support for the FYFV Primary Care.
Workforce Addition of achievements to date, governance arrangements and improving recruitment and retention.
Digital Addition of track record in working together across NWL, greater detail was provided on the enabling work streams including digital health to leverage innovations.

1.5 Finance
The October submission has a £1.4bn financial gap by 2021 in our health and social care system in the 'do nothing' scenario (in June this was stated as £1.3bn). The finance section has been reviewed and refreshed throughout, in line with developments during the period July to October. There are several key changes to note:

The October STP financial and capital projections include London Ambulance Service (NWL only) and the Royal Brompton & Harefield NHS Foundation Trust, both within our NWL footprint but primarily commissioned by NHSE. Their data is captured under 'providers'.

Under the 'do something' scenario (consisting of business as usual savings expected to be delivered and with savings realised through the STP DAs) the total NWL STP financial residual gap at 2020/21 (assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care) has moved favourably to (£19.6m) in October from (£30.6m) in June, this is largely driven by improvements in the CCG financial position.

The investment in each of the DA plans and the assumptions for gross savings are revised throughout the October submission and the financial risk log was updated.

1.6 Communications and Engagement
A new appendix presents the guiding principles for engagement with patients, residents and staff. The events and engagement methods are listed with an analysis of feedback on the STP priorities and DAs.

2. Recap of the Key Themes in the NWL STP October 2016 Submission
2.1 North West London Context
In developing the NWL STP, the eight boroughs and commissioning groups, acute, mental health and community service providers are working together to improve the health and wellbeing of a population of 2.1m and 2.3m registered patients with an annual health and social care spend of £4bn.

2.2 Understanding the Needs of our Population: Addressing the FYFV Three Gaps
Around a third of patients currently in one of our inpatient beds could be better cared for in

the community or at home. Many are frail, elderly people and others with complex, long-term physical and/or mental health conditions. They remain in hospital simply because the support and services they need to go home or to a residential care facility aren't easily available at the right time.

We also know that there will continue to be big increases in the number of people with one or more long-term conditions, such as diabetes or arthritis by around a third and advanced dementia and Alzheimer's increasing by 40% by 2030. Proactive care to help people stay as healthy and independent as possible and manage their own conditions will need to be very different to the reactive treatment we tend to provide now. We need to move to a health and social care system that:

- helps people to be as healthy as possible
- helps people who become unwell to get faster access to care that will get them back to health as quickly as possible
- joins up care and services and makes it easier for individuals to get the right health and care support for them
- encourages partnership working between health and care providers and the individuals they serve

2.3 Health and Wellbeing

There are specific health and wellbeing challenges across the NWL footprint that contribute to healthcare demand such as:

- 20% of people have a long term condition
- 50% of people over 65 live alone
- 10 – 28% of children live in households with no adults in employment
- 1 in 5 children aged 4-5 are overweight.

In addition wider determinants of health, such as the high proportions living in poverty and overcrowded households, high rates of poor quality air across different boroughs, only half of our population are physically active, nearly half of our 65+ population are living alone increasing the potential for social isolation with over 60% of our adult social care users wanting more social contact, all contribute additional high cost, complex needs to an already stretched health system.

2.4 Care and Quality

There are significant variations in utilisation and quality of health and care which show that:

- 30% of patients in acute hospitals should be cared for in more appropriate care settings
- people with serious and long term mental health needs have a life expectancy 20 years less than those with no mental health needs
- for those needing end of life care over 80% indicated a preference to die at home while only 22% were supported to do this.

2.5 Finance and Efficiency

Transformational change is necessary to address a significant financial challenge across the NWL footprint where, if we do nothing (assuming the delivery of 206/17 plans) there will be a £1.4bn financial gap by 2021 in our health and social care system.

2.6 Our NWL STP: Vision, Priorities, Delivery Areas, Plans and Enablers

2.6.1 The Vision for NWL

The vision for NW London is that 'everyone living, working and visiting here has the opportunity to be well and live well – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country'. The principles underpinning the vision reflect the aims of our Clinical Strategy. Care will be:

- Personalised

- Localised
- Co-ordinated
- Specialised.

In the future system care will be transformed to focus on self-care, wellbeing and community interventions so that resources may be targeted to areas of most need including investment in areas with the greatest potential to improve health and wellbeing for NWL residents. The approach to commissioning will be transformed by increasing the collaboration with social care and the wider community. Key changes include an expansion of local pooled budgets and implementing Accountable Care Partnerships across NWL with capitated budgets, population based outcomes and joint commissioning.

2.6.2 Nine Priorities

There are nine priorities in our STP drawn from local place based planning across health and social care:

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves
2. Improve children's mental and physical health and well-being
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: Cancer, heart disease, respiratory disease
4. Reduce social isolation
5. Reduce unwarranted variation in the management of long term conditions
6. Ensure people access the right care in the right place at the right time
7. Improve the overall quality of care for people in the last phase of life and enable them to die in their place of choice
8. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population
9. Improve consistency in patient outcomes and experience regardless of the day of the week services are accessed

2.6.3 Five DAs and their Plans

Resources across our footprint will be shifted to focus on achieving change in five DAs that address the nine priority areas of population need across the partner organisations. Each DA, shown in the table below, has a jointly led work programme with a senior responsible officer, senior clinical responsible officer and support.

Delivery area (DA)	**Plans October 2016 Submission**
DA1.Radically upgrade prevention and wellbeing	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children the get the best start in life
DA2. Eliminating unwarranted variation and improving long term condition management	a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. Improve self-management and 'patient activation'
DA3. Achieving better outcomes and experiences for older people	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
DA4. Improving outcomes for children &adults with mental health needs	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
DA5. Ensuring we have safe, high quality sustainable	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards

acute services	c. Reconfiguring acute services d. NW London Productivity Programme

Our STP includes a high level financial analysis on how the plans will address the scale of the financial challenge. The underlying assumptions will require further testing and the programmes will require further refinement over the term of the STP to gain assurance that the DAs will support a sustainable financial position across NWL.

2.6.4 Three Enablers

At the heart of the NWL STP is a desire to increase collaborative working and breakdown organisational silos. Shared approaches to estates, digital capabilities and workforce are presented as essential enablers in our STP work programme.

2.7 Governance of the NWL STP

The project groups report via their leads to a DA Programme Board which then reports upwards to the Joint NWL Health and Care Transformation Group (JH&CTG), our Chief Executive, Dr Tracey Batten, is a member and is also joint programme sponsor for DA5. The JH&CTG does not have delegated authority as a decision making forum from the STP partner's own Boards or Governing Bodies – decision making authority remains through the partner's own governance forums.

We have developed proposals for a Trust STP Forum as our local delivery and governance framework – bringing together our representatives in each of the DAs, enabling and advisory groups to share information on opportunities and to be sighted on risks. ExCo will be asked to approve this groups terms of reference in December.

It is important to note that in the October STP submission six out of the eight local boroughs signed up to a joint statement on Health and Care Collaboration in NWL, the two remaining boroughs, Ealing and Hammersmith and Fulham, have indicated concerns that remain around the NHS's proposals developed through the Shaping a Healthier Future programme. All STP partners have therefore committed to review the assumptions underpinning the proposed changes to acute services in NWL before making further changes. Therefore the NWL STP which covers the five year period to 2021 does not envisage changes to Charing Cross Hospital in this timeline.

Quality impact:

Successful implementation of the NWL STP aims to reduce unwarranted variations in quality of care support improved outcomes.

Financial impact:

Nationally the STP is the main route to accessing the STF, subject to all eligibility caveats being met and locally seeks to reduce demand and build a high quality and sustainable health and care system across NWL.

Risk impact:

Risk associated with the STP work programme include financial risks in the short–term for acute providers as resource allocation and commissioning intentions are reshaped, eligibility and timing to access STF.

Recommendation to the Trust board:

The Trust board is asked to note the changes in the STP submitted in October 2016 and the Trust STP Forum as our local governance and delivery framework, and to ratify the NWL STP submission.

Trust strategic objectives supported by this paper:
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion. To educate and engage skilled and diverse people committed to continual learning and improvements. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care. To pioneer integrated models of care with our partners to improve the health of the communities we serve. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance .

Author	Responsible executive director	Date submitted
Anne Mottram, Director of Strategy	Dr Tracey Batten Chief Executive	23 November 2016

NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

V01

21 October 2016

Foreword

The National Health Service (NHS) is one of the greatest health systems in the world, guaranteeing services free at the point of need for everyone and saving thousands of lives each year. However, we know we can do much better. The NHS is primarily an illness service, helping people who are ill to recover – we want to move to a service that focuses on keeping people well, while providing even better care when people do become ill. The NHS is a maze of different services provided by different organisations, making it hard for users of services to know where to go when they have problems. We want to simplify this, ensuring that people have a clear point of contact and integrating services across health and between health and social care. We know that the quality of care varies across North West (NW) London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services. We know that health is often determined by wider issues such as housing and employment – we want to work together across health and local government to address these wider challenges. We also know that as people live longer, they need more services which increases the pressures on the NHS at a time when the budget for the NHS is constrained.

NHS England has published the Five Year Forward View (FYFV), setting out a vision for the future of the NHS. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV 'Triple Aims' of improving people's health and well being, improving the quality of care that people receive and addressing the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next five years and focus on the needs of people living in the STP area, rather than individual organisations.

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions. We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.4bn funding shortfall and develop a balanced, sustainable financial system which our plan addresses.

We can only achieve this if we work together in NW London working at scale and pace, not just to address health and care challenges but also the wider determinants of health including employment, education and housing. We know that good homes, good jobs and better health education all contribute towards healthier communities that stay healthy for longer. Our joint plan sets out how we will achieve this aim, improve care and quality and deliver a financially sustainable system. We have had successes so far but need to increase the pace and scale of what we do if we are going to be successful. We have listened to the feedback we have received so far from our patients and residents and updated our plan in particular around access to primary care and the delivery of mental health services. We will continue to engage throughout the lifetime of the plan.

Concerns remain around the NHS's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in NW London. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical quality and safety concerns and expected demand pressures. We recognise that we don't agree on everything, however it is the shared view of the STP partners that this will not stop us working together to improve the health and well-being of our residents.

Dr Mohini Parmar
Chair, Ealing Clinical Commissioning Group and NW London STP System Leader

Carolyn Downs
Chief Executive of Brent Council

Clare Parker
Chief Officer Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

Tracey Batten
Chief Executive of Imperial College Healthcare NHS Trust

Rob Larkman
Chief Officer Brent, Harrow and Hillingdon CCGs

Contents Page

	SECTION	SUB- SECTION	PAGE
i	**Executive Summary**		4
1	**Case for Change**		12
2	**Delivery Areas**		20
		DA1 - Radically upgrading prevention and wellbeing	21
		DA2 - Eliminating unwarranted variation and improving LTC management	23
		DA3 - Achieving better outcomes and experiences for older people	27
		DA4 - Improving outcomes for children &adults with mental health needs	29
		DA5 - Ensuring we have safe, high quality sustainable acute services	31
3	**Enablers**		34
		Estates	35
		Workforce	39
		Digital	42
4	**Primary Care**		44
5	**Finance**		50
6	**Risks**		55
7	**References**		57
	Appendices	*Please see separate document*	

i. Executive Summary:
Health and social care in NW London is not sustainable

In NW London there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. But this challenge also gives us an opportunity. We know that our services are siloed and don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued.

We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

The health and social care challenges we face are: building people centric services, doing more and better with less and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Health & Wellbeing	▪ Adults are not making healthy choices ▪ Increased social isolation ▪ Poor children's health and wellbeing	▪ 20% of people have a long term condition[1] ▪ 50% of people over 65 live alone[2] ▪ 10 – 28% of children live in households with no adults in employment[3] ▪ 1 in 5 children aged 4-5 are overweight[4]
Care & Quality	▪ Unwarranted variation in clinical practise and outcomes ▪ Reduced life expectancy for those with mental health issues ▪ Lack of end of life care available at home	▪ Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places[5] ▪ People with serious and long term mental health needs (e.g. schizophrenia) have a life expectancy up to 20 years less than the average[6] ▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7]
Finance & Efficiency	▪ Deficits in most NHS providers ▪ Increasing financial gap across health and large social care funding cuts ▪ Inefficiencies and duplication driven by organisational not patient focus	▪ If we do nothing, there will be a £1.4bn financial gap by 2021 in our health and social care system and potential market failure in some sectors ▪ Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where we need to target our funding. Segmentation offers us a consistent approach to understanding our population across NW London. Population segmentation will also allow us to contract for outcomes in the future.

NW London's population faces a number of challenges as the segmentation below highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans. We also need to be mindful of the wider determinants of health across all of these segments; specifically the importance of suitable housing, employment opportunities, education and skills, leisure and creative activities - which all contribute to improved emotional, social and personal wellbeing, and their associated health outcomes.

Please note that segment numbers are for adults only with the exception of the children segment

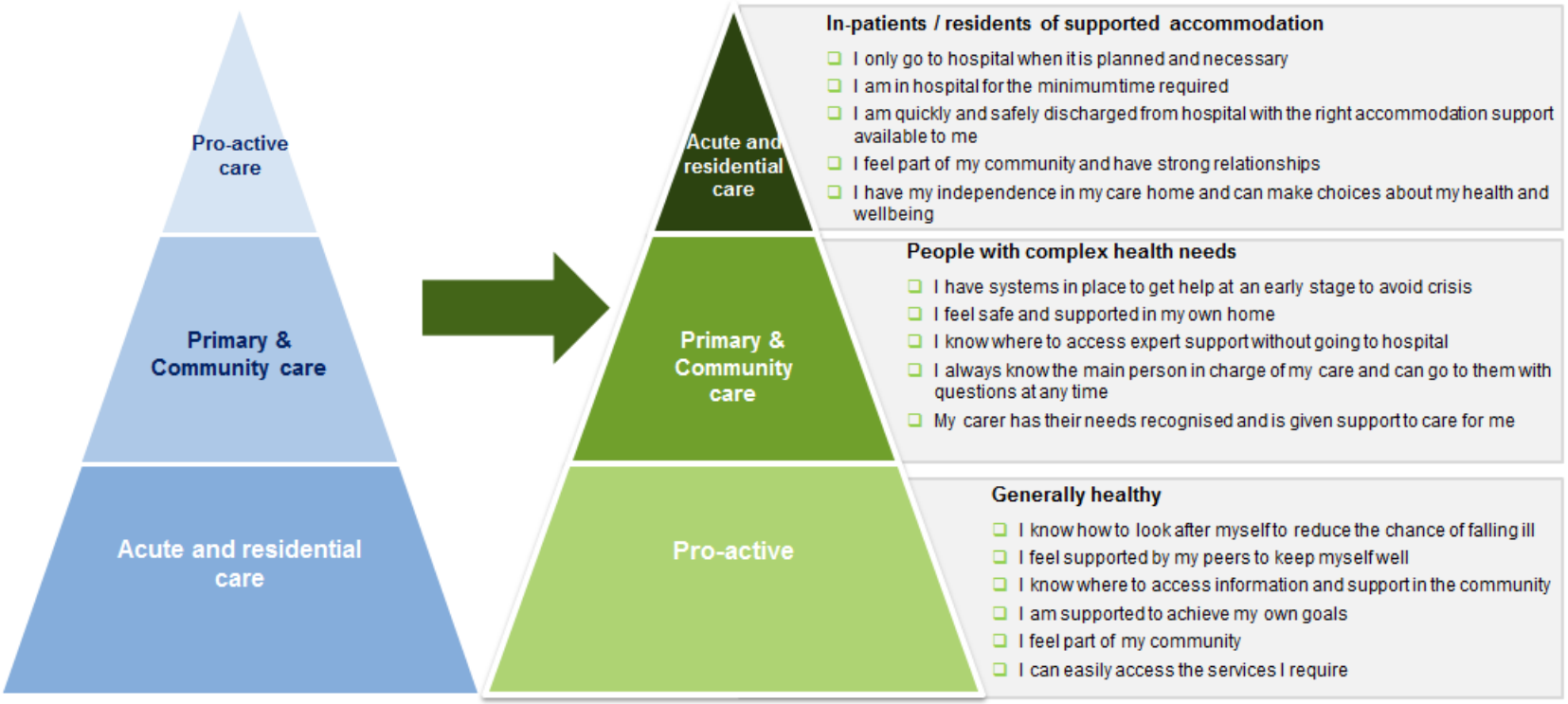
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,000	458,000	26,000	43,300	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	16%	29%	29%	40%	6%	

i. Executive Summary:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, which will improve the health & wellbeing of our residents.

i. Executive Summary:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children the get the best start in life
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. Improve self-management and 'patient activation'
Improving care & quality	4	Reduce social isolation					
	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	482,700 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

i. Executive Summary:
Existing health service strategy

This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well: addressing the wider determinants of health, such as employment, housing and social isolation, enabling people to make healthy choices, proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible and reabling people to regain independence whenever possible. When people do need more specialist care this needs to be available when needed and to be of consistently high quality with access to senior doctors seven days a week. Too often people are being brought into hospital unnecessarily, staying too long and for some dying in hospital when they would rather be cared for at home.

The health system in NW London needs to be able to meet this ambition, and for the last few years doctors, nurses and other clinicians have come together as a clinical community across primary, secondary and tertiary care to agree how to transform health care delivery into a high quality but sustainable system that meets patients' needs. This is based on three factors:

Firstly, the transformation of general practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care. We will deliver this through primary care operating at scale through networks, federations of practices or super-practices, working with partners to deliver integrated care (Delivery Areas 1-3).

Secondly, a substantial upscaling of the intermediate care services available to people locally offering integrated health and social care teams outside of an acute hospital setting (Delivery Area 3). The offering will be consistent, simple and easy to use and understand for professionals and patients . This will respond rapidly when people become ill, delivering care in the home, in GP practices or in local services hubs, will inreach into A&E and CDU to support people who do not need to be there and can be cared for at home and facilitate a supported discharge from hospitals as soon as the individual is medically fit. The services will be fully integrated between health and social care.

Thirdly, acute services need to be configured at a scale that enables the delivery of high quality care, 7 days a week, giving the best possible outcomes for patients (Delivery Area 5). As medicine evolves, it benefits from specialisation and innovation. The benefits of senior clinical advice available at most parts of the day are now well documented to improve outcomes as it enables the right treatment to be s delivered to the patient at the right time We know from our London wide work on stroke and major trauma that better outcomes can be achieved by consolidating specialist doctors into a smaller number of units that can deliver consistently high quality, well staffed services by staff who are experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills. In 2012 the NHS consulted on plans to reduce the number of major hospitals in NW London from 9 to 5, enabling us to drive improvements in urgent care, maternity services and children's care. The major hospitals will be networked with a specialist hospital, an elective centre and two local hospitals, allowing us to drive improvements in care across all areas.

Our STP sets out how we will meet the needs of our population more effectively through our proactive care model. We also have increasing expectations of standards of service and availability of services 24/7, driving financial and workforce challenges. We will partially address the financial challenges through our NW London Productivity Programme, but even if the demand and finance challenges are addressed, our biggest, most intractable problem is the lack of skilled workforce to deliver a '7 day service' under the current model across multiple sites. The health system is clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care, and without reconfiguring acute services to enable us to staff our hospitals safely in the medium term.

The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. We wish to maintain and build on that through our new vision for Ealing, serving the community with an A&E supported by a network of ambulatory care pathways and centre of excellence for elderly services including access to appropriate beds. The site would also allow us to deliver primary care to scale with an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs. Due to the on-going uncertainty of the future of Ealing Hospital the vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. As Ealing currently has a financial deficit of over £30m as the costs of staffing it safely are greater than the activity and income for the site, the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period.

A joint statement from six boroughs is at Appendix A. Ealing and Hammersmith & Fulham Councils do not support the STP due to proposals to reconfigure acute services in the two respective boroughs. Both councils remain fully committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

The focus of the STP for the first two years is to develop the new proactive model of care across NW London and to address the immediate demand and financial challenges. No substantive changes to A&Es in Ealing will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

There is a similar vision for Charing Cross Hospital. Here, again, we plan to deliver ambulatory care, primary care to scale and an extensive range of diagnostic services. However at Charing Cross, during this STP period, there are no planned changes to the A&E services currently being provided.

i. Executive Summary:
Finances

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £298m gap in social care, giving a system wide shortfall of £1,410m.

Through a combination of normal savings delivery and the benefits that will be realised through the five STP delivery areas, the financial position of the health sector is a £15.1m surplus, and the social care deficit is £35m, giving an overall sector deficit of £19.9m.

Table: North West London Footprint position in 20/21

£'m	CCGs	Acute	Non-Acute	Spec. Comm	Primary Care	STF Investment	Sub-total (Health)	Social Care	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Do Nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	**-**	**(1,112.4)**	**(297.5)**	**(1,409.9)**
Business as usual savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	**108.5**	**680.6**
DA 1-5 - Investment	(118.3)	-	-	-	-	-	**(118.3)**	**-**	**(118.3)**
DA1-5 - Savings	302.9	120.4	23.0	-	-	-	**446.3**	62.5	**508.8**
Additional costs of delivering 5YFV	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	**-**	**1,127.5**	**262.5**	**1,390.0**
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	**-**	**-**	**-**	**15.1**	**(35.0)**	**(19.9)**

Schemes have been identified which support the shift of patient care from acute into local care settings, and include transformational schemes across all points of delivery. The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the areas of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes

These schemes, as well as improving patient outcomes, are expected to cost less – requiring £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings.

In addition, the solution includes £570m of business as usual savings (CIPs and QIPP), the majority delivered by the acute providers, which relate to efficiencies that can be delivered without working together and without strategic change. Each of the acute providers has provided details of their governance and internal resources and structures to help provide assurance of deliverability.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, mainly attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for most providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing, once it can be demonstrated that reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met.

The remaining deficit is due to London Ambulance Service (NWL only) and Royal Brompton & Harefield, who are within the NWL footprint but primarily commissioned by NHS England.

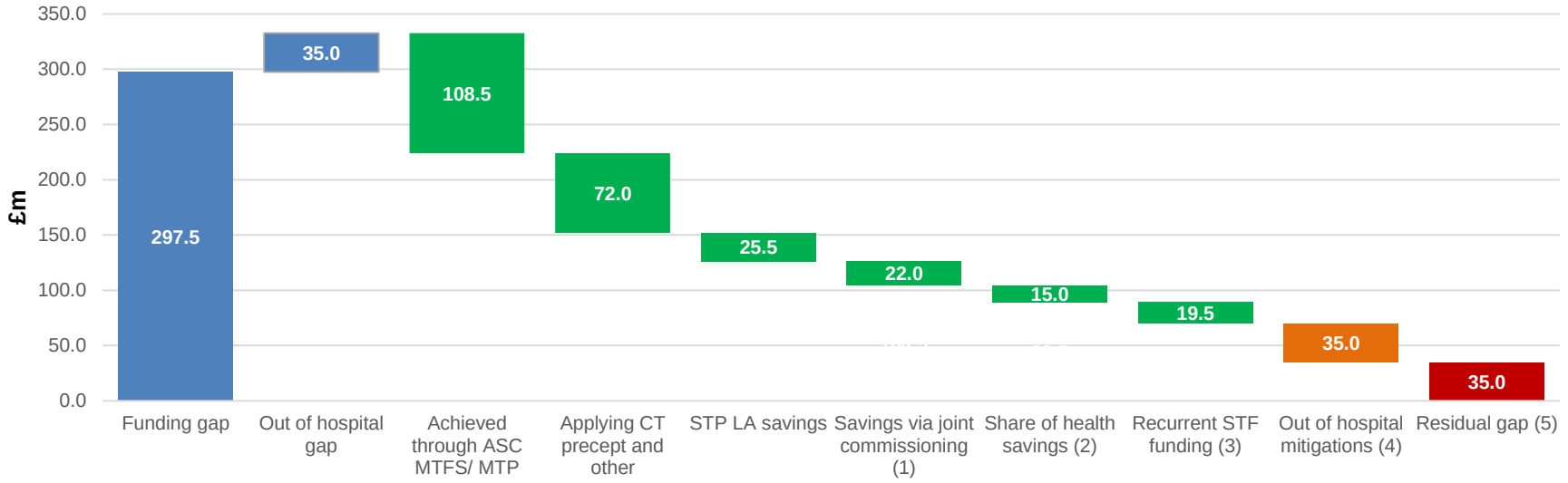
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

NWL also seeks access to public capital funds, as an important enabler of clinical and financially sustainable services and to ensure that services are delivered from an appropriate quality environment.

i. Executive Summary:
Social Care Finances (I)

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. In addition to this there continues to be a significant level of service and demographic pressures putting further strain on the service. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The chart below sets out below the projected gap and how this will be addressed. The savings are further broken down on the following slide.



The following assumptions and caveats apply:
The residual gap of £35m by 20/21 will be addressed through further joint working between health and social care. An initial estimated cost pressure of £35m illustrates the likely shift from hospital activity into adult social care, which is to be addressed through a robust business case process. £19.5m is assumed to be funded by STF on a recurrent basis, leaving an unresolved recurrent gap of £35m.

(1) Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3;
(2) The share of savings accruing to Health are assumed to be shared equally with local government on the basis of performance;
(3) Assumed that £19.5m will be recurrent funding from 2020/21through the STF fund;
(4) Further work is required to identify the impact on social care of the Delivery Area schemes, and to develop joined up health and social care business cases. Where the Delivery Area schemes result in a shift of costs to social care, it is expected that these would be NHS funded;
(5) The residual gap of £35m by 20/21 is assumed to be unresolved but both Local Government and NHS colleagues will be working collaboratively to identify how to close this gap, so as to put both the health and social care systems on sustainable footing.
NB Confirmation of what the final on-going sources of funding will be from 2020/21 is being sought.

i. Executive Summary:
Social Care Finances (2)

The table below sets out how the savings accruing to local authorities from joint work with Health on the Delivery Area business cases will be delivered through the investment of transformation funding:

Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health** (£M)
Public Health & prevention	DA1	**-**	**2.0**	**2.0**	**2.2**
Demand management & community resilience	DA2	**-**	**-**	**-**	**6.1**
Caring for people with complex needs	DA3	**-**	**-**	**-**	**5.1**
Accommodation based care	DA3	**7.7**	**-**	**7.7**	**2.0**
Discharge	DA3	**3.4**	**-**	**3.4**	**9.6**
Mental Health	DA4	**3.5**	**2.9**	**6.4**	**5.0**
Vulnerable	DA1	**3.0**	**3.0**	**6**	**-**
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	**22.0**	**-**	**22.0**	**TBC**
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:
To deliver the savings requires non-recurrent transformational investment from the NHS Sustainability and Transformation Fund of an estimated £110m over 3 years (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services. The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

i. Executive Summary:
16/17 key deliverables

Our plan is ambitious and rightly so – the challenges we face are considerable and the actions we need to take are multifaceted. However we know that we will be more effective if we focus on a small number of things in each year of the five year plan, concentrating our efforts on the actions that will have the most impact.

We have an urgent need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable. For year 1 we are therefore targeting actions that take forward our strategy and will have a quick impact. To help us achieve the longer term shift to the proactive care model we will also plan and start to implement work that will have a longer term impact. Our focus out of hospital in 2016/17 will therefore be on care for those in the last phase of life and the strengthening of intermediate care services by scaling up models that we know have been successful in individual boroughs. In hospital we will focus on reducing bank and agency spend and reducing unnecessary delays in hospital processes through the 7 Day Programme.

We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

Areas with impact in 2016/17

Delivery area	What we will achieve	Impact
DA1	i. Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery ii. Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems	i. A shared understanding of public and professional responsibility for use of services ii. Maximising opportunities working jointly to support people with mental health problems, resulting in benefits to the health system and wider local economy
DA2	i. Increased accessibility to primary care through extended hours and via a variety of channels (e.g. digital, phone, face-to-face) ii. Enhanced primary care with focus on providing more proactive and co-ordinated care to patients iii. Comprehensive diabetes performance dashboard at practice and CCG level iv. Delivery of Patient Activation Measure Year 1 targets as part of the self care framework	i. Delivering extended access for Primary Care, 8am – 8pm, 7 days a week, leading to additional appointments available for patients out of hours, every week, as well as a reduction in NELs and A&E attendances ii. Unique, convenient , efficient and better care for patients as well as supporting sustainability and delivering accountable care for patients iii. Improve health and wellbeing of local diabetic population iv. Enable more patients with an LTC to self-manage
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17 ii. Training and support to care homes to manage people in their last phase of life iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service iv. Deployed the NW London Whole Systems Integrated Care dashboards and databases to 312 practices to support direct care, providing various views including a 12 month longitudinal view of all the patients' health and social care data. ACP dashboards also deployed	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9] ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10] iii. Full impact to be scoped but this is part of developing a fully integrated older person's service and blue print for a NW London model at all hospital sites iv. Improved patient care, more effective case finding and risk management for proactive care, supports care coordination as integrated care record provided in a single view
DA4	i. All people with a known serious and long term mental health need are able to access support in crisis 24/7 from a single point of access (SPA) ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11] ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint safer staffing programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely iii. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13] iii. We will achieve a Q4 15/16 to Q4 16/17 reduction of 0.5 day LOS on average for patients currently waiting longer than 24hrs for a scan. This will increase to a 1 day reduction in 17/18[14]

1. Case for Change:

Understanding the NW London footprint and its population is vital to providing the right services to our residents

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

NW London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford and which include landmarks such as Big Ben and Wembley Stadium. The area is also undergoing major infrastructure development with Crossrail, which will have a socio economic impact beyond 2021.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in NW London – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- Some NW London boroughs have the highest life expectancy differences in England. In one borough men experience 16.04 year life expectancy difference between most deprived and least[1]
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average [2]
- If we do nothing, there will be a £1.4bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the wider determinants of health and wellbeing such as housing, education and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs**. In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

1. Case for Change:
Working together to address a new challenge

To enable people to **be well and live well**, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities.

Working in partnership with patient and community representatives, in 2016/17 we will produce a **People's Health & Wellbeing Charter** for NW London. This will set out the health and care offer so that people can access the right care in the right place at the right time. As part of this social contract between health and care providers and the local community, it will also set out the 'offer' from people in terms of how they will look after themselves.

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

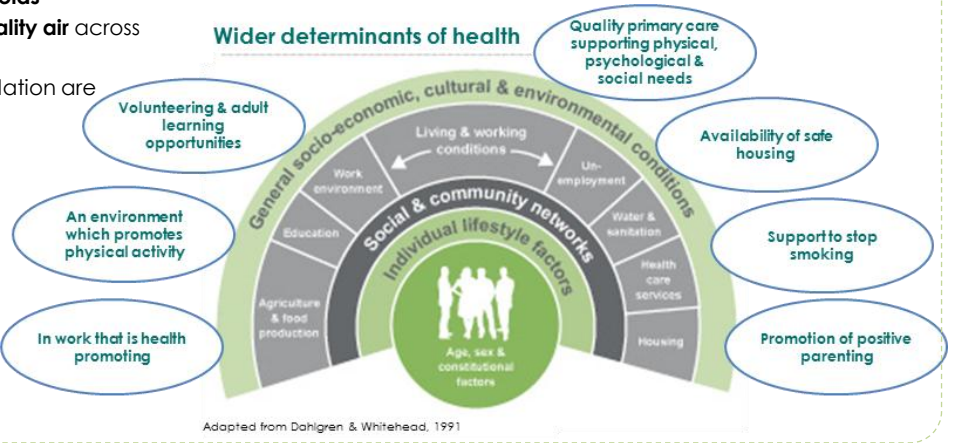
1. Case for Change:
Understanding our population

In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (>50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- State primary school **children with high levels of obesity**

In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

- High proportions living in **poverty and overcrowded households**
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**



Adapted from Dahlgren & Whitehead, 1991

Population Segmentation for NW London 2015–30[3]

Mostly healthy
- 1,216,000 adults in NW London are mostly healthy
- 58% of the total population
- 24% of care spend in NW London

In 2030:
- 4% more adults
- 31% more +65s

One or more long-term conditions
- 338,000 adults in NW London have 1 or more LTC
- 16% of the population
- 22% of the care spend in NW London

In 2030:
- 35% more adults
- 37% more spend in NW London

Cancer
- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4.5% of care spend in NW London

In 2030:
- 53% more adults
- 50% more spend in NW London

Serious and long term mental health needs
- 37,500 adults in NW London have serious and long term mental health needs
- 2% of population
- 7.5% of care spend

In 2030:
- 16% more adults
- 21% more spend in NW London

Learning disability
- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8% of care spend in NW London

In 2030:
- 29% more adults
- 35% more spend in NW London

Severe physical disability
- 21,000 adults in NW London have severe physical disabilities
- 1% of the population
- 18% of care spend in NW London

In 2030:
- 29% more adults
- 26% more spend in NW London

Advanced dementia / Alzheimer's
- 5,000 adults in NW London have advanced dementia
- 0.2% of the population
- 2% of care spend in NW London

In 2030:
- 40% more adults
- 44% more spend in NW London

Children
- 438,200 children in NW London
- 21% of the population
- 14% of care spend in NW London

In 2030:
- 6% more children
- 3% more spend in NW London

Socially Excluded Groups
- Westminster has the highest recorded population of rough sleepers of any local authority in the country
- There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where our investment is needed. Segmentation offers a consistent approach to understanding our population across NW London. NW London's population faces a number of challenges as the segmentation (left) highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans.

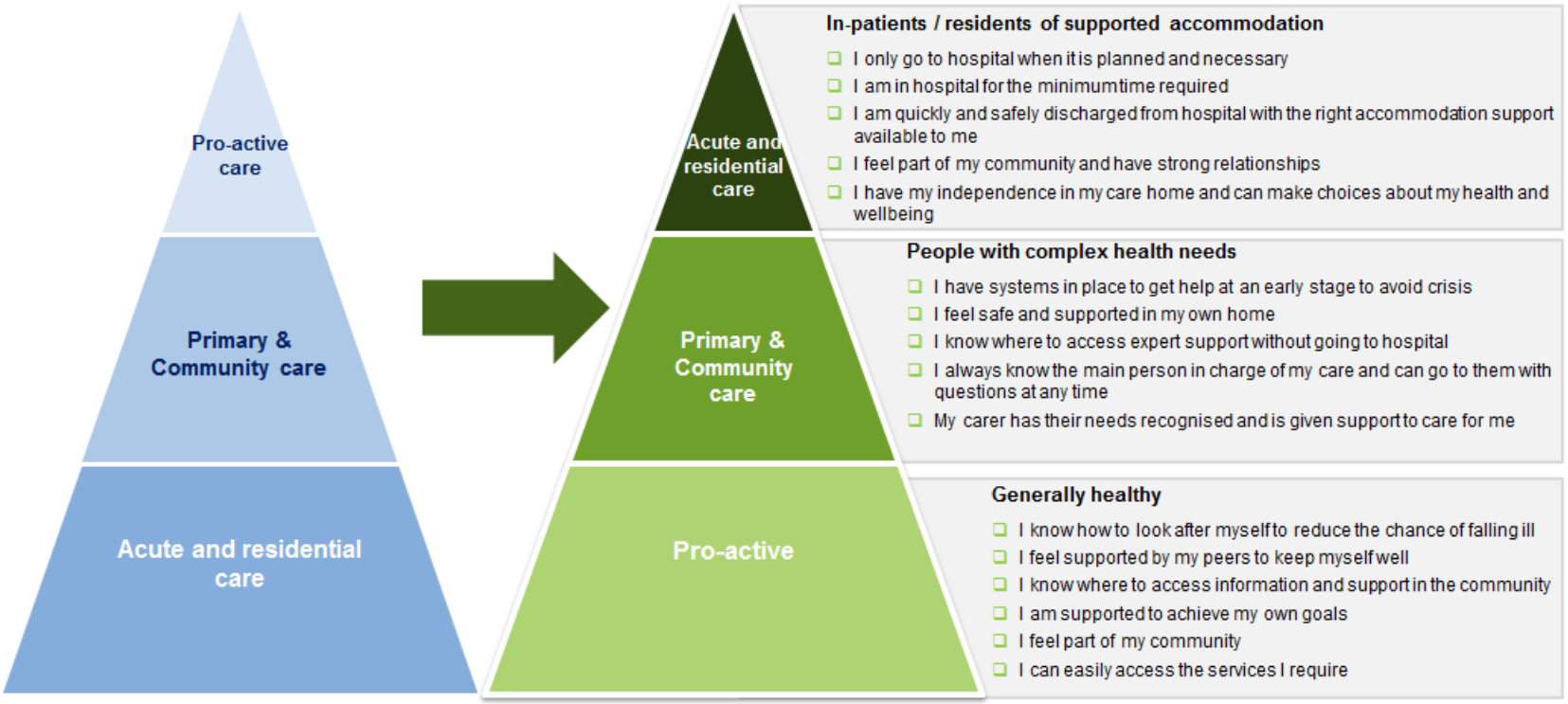
Please note that segment numbers are for adults only with the exception of the children segment

1. Case for Change:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care as close to, or in people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health and wellbeing of our residents.

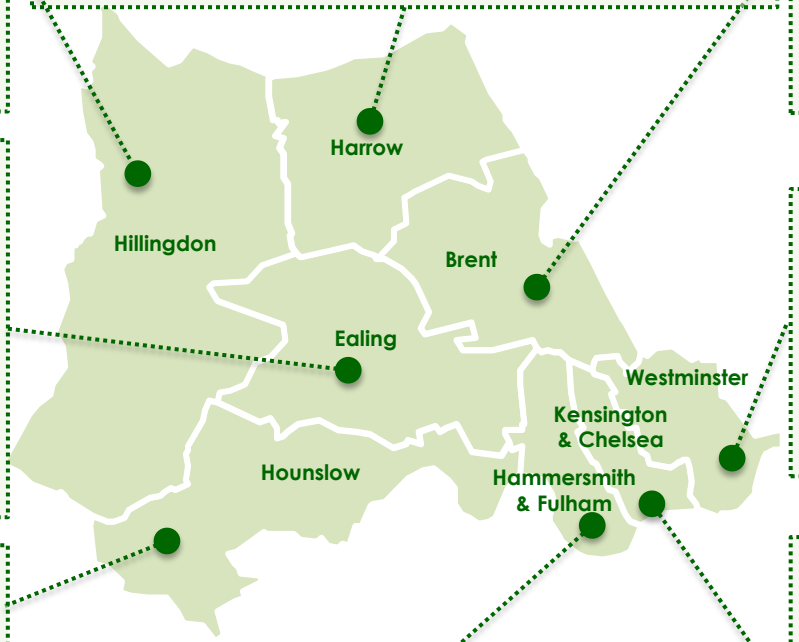
1. Case for Change:
Understanding people's needs

While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BAME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease
- Currently 9.3% of Reception aged children being obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6

- **Brent** is ranked amongst the top 15% most-deprived areas in the country
- The population is young, with 35% aged between 20 and 39
- Brent is ethnically diverse with 65% from BAME groups
- It is forecast that by 2030 15% of adults in Brent will have diabetes
- Children in Brent have worse than average levels of obesity – 10% of children in Reception, 24% of children in Year 6



- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 19.5% rise in the number of people over 65 years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)

- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2014, Westminster had the 6th highest reported new diagnoses of Sexually Transmitted Infections (excluding Chlamydia aged < 25) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

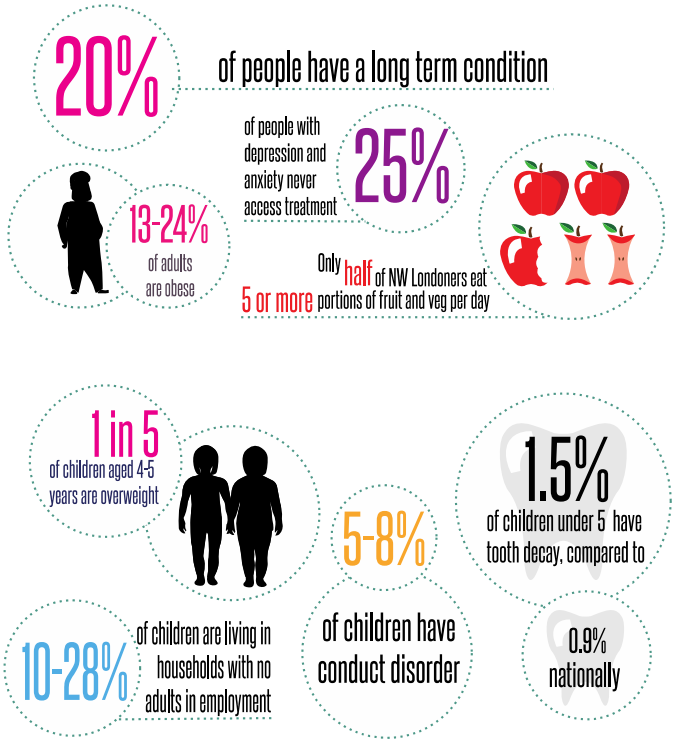
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD

- **Kensington & Chelsea** serves a diverse population of 179,000 people and has a very large working age population and a small proportion of children (the smallest in London)
- Half of the area's population were born abroad
- The principal cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

1. Case for Change:
Health and Wellbeing Current Situation

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…



1500 people under 75 die each year from cancer, heart diseases and respiratory illness.

If we were to reach the national average of outcomes, we could save 200 people per year.

Our to-be…

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.

Our Priorities

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves
2. Improve children's mental and physical health and well-being
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

My life is important, I am part of my community and I have opportunity, choice and control

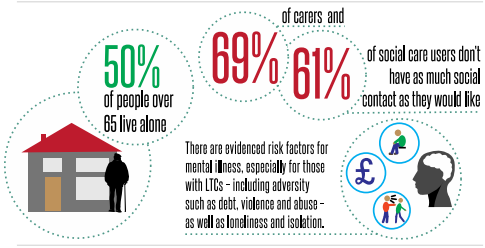
As soon as I am struggling, appropriate and timely help is available

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

My wellbeing and happiness is valued and I am supported to stay well and thrive

I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health and preventing escalation of mental health needs	4 Reduce social isolation
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
Over 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy circa 20 years less than the average and the number of people in this group in NW London is double the national average.	People are supported holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

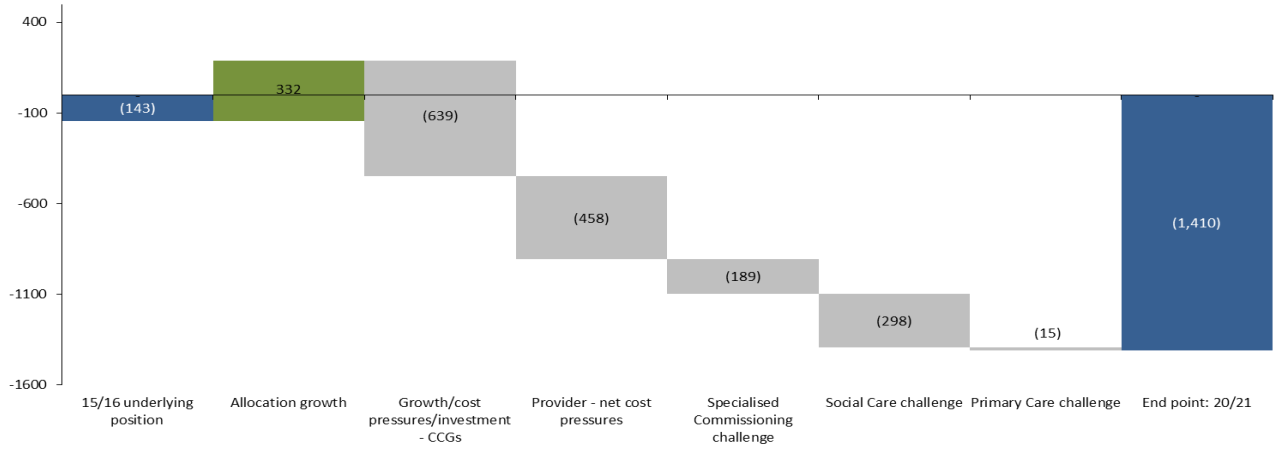
Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

1. Case for Change:
Overall Financial Challenge – Do Nothing

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £297m gap in social care, giving a system wide shortfall of £1,410m.

The bridge below presents the key drivers for the revised 20/21 'do nothing' scenario, as shown on the previous slide. The table below the bridge shows the profile of the 'do nothing' scenario over the five year period.

Profile of the 'Do nothing' movement in financial position 2015/16 to 2020/21



Profile of the 'Do Nothing' financial challenge by organisation outturn 17/18 to 20/21

Sector	17/18	18/19	19/20	20/21
	£'m	£'m	£'m	£'m
Providers	(403)	(493)	(579)	(661)
CCGs	(77)	(140)	(198)	(248)
Spec Comm	(44)	(90)	(138)	(189)
Primary Care	(1)	(12)	(19)	(15)
Total NHS	**(525)**	**(735)**	**(934)**	**(1,113)**
Social Care	(74)	(148)	(223)	(297)
Total Health & Social Care	**(599)**	**(883)**	**(1,157)**	**(1,410)**

2. Delivery Areas:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace to achieve our priorities. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children to get the best start in life
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. Improve self-management and 'patient activation'
Improving care & quality	4	Reduce social isolation					
	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	482,700 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

2020/2021

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible

Target Population:

All adults: 1,641,500
Mostly Healthy Adults at risk of developing a LTC: 121,680
All children: 438,200

Contribution to Closing the Financial Gap

£11.6m

- **21% of NW Londoners are physically inactive[17] and over 50% of adults are overweight or obese[18]**
- **Westminster has the highest population of rough sleepers in the country[19]**
- **1 in 5 children aged 4-5 years are overweight and obese in NW London**
- **Around 200,000 people in NW London are socially isolated**

Why this is important for NW London

- NW London residents are living longer but living less healthy lifestyles than in the past, and as a result are developing more long term conditions (LTCs) and increasing their risk of developing cancer, heart disease or stroke. There are currently 338,000 people living with one or more LTC, and a further 121,680 mostly healthy adults at risk of developing an LTC before 2030[1].
- Those at risk are members of the population who are likely to affected by poverty, lack of work, poor housing, isolation and consequently make unhealthy lifestyle choices, such as eating unhealthily, smoking, being physically inactive, or drinking a high volume of alcohol. We will support positive choices through sexual health service transformation. Our residents who have a learning disability are also sometimes not receiving the full support they need to live well within their local community.
- In NW London, some of the key drivers putting people at risk are:
  - Unhealthy lifestyle choices - only half of the population achieves the recommended amount of physical activity per week[2]. 6 of the 8 Boroughs have higher rates of increasing risk alcohol drinkers than the rest of London and c.14% smoke[3].
  - Rates of drinking are lower in London than the rest of the UK overall. However, alcohol related admissions have been increasing across London. In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs[10].
  - An increasing prevalence of social isolation and loneliness, which have a detrimental effect on health and well-being - 11% of the UK population reported feeling lonely all, most or more than half of the time[5].
  - Deprivation and homelessness, which are very high in some areas across NW London. Rough sleepers attend A&E around 7 times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays[6].
  - Mental health problems - almost half the people claiming Employment Support Allowance have a mental health problem or behavioural difficulty[7]. Evidence suggests that 30% of them could work given the right sort of help[8].
- For NW London, the current trajectory is not sustainable. In a 'do nothing' scenario by 2020 we expect to see a 12% increase in resident population with an LTC and a 13% increase in spend, up from £1bn annually. By 2030, spend is expected to increase by 37%, an extra c.£370m a year[9].
- Targeted interventions to support people living healthier lives could prevent 'lifestyle' diseases, delay or stop the development of LTCs and reduce pressure on the system. For example, It has been estimated that a 50p minimum unit price would reduce average alcohol consumption by 7% overall[4].
- Furthermore, recent findings from the work commissioned by Healthy London Partnership looking at illness prevention showed that intervention to reduce smoking could realise savings over five years of £20m to £200m for NW London (depending on proportion of population affected)[10].
- This work also suggests that reducing the average BMI of the obese population not only prevents deaths (0.2 deaths per 100 adults achieving a sustained reduction in BMI by 5 points from 30), but also improves quality of life by reducing incidence of CHD, Stroke, and Colorectal and breast cancer.

Our aim is therefore to support people to stay healthy. We will do this by:

- Developing a number of cross cutting approaches which will amplify the interventions described below and overleaf – embedding Making Every Contact Count and supporting national campaigns being 2 such examples.
- Interventions that are focused on **keeping our whole population well** and supporting them to adopt more healthy lifestyles – whether they are currently mostly healthy, have learning or physical disabilities, or have serious and enduring mental health needs. This will also prevent people from developing cancer, as according to Cancer Research UK, cancer is the leading cause of premature death in London but 42% are preventable and relate to lifestyle factors[12].
- Targeted work with the population who **need mental health support** – the mortality gap is driven largely through unhealthy lifestyles and barriers to accessing the right support. We will work to address the wider determinants of health, such as employment and housing, where there is good evidence of impact. Social isolation, whether older people, single parents, or people how need mental health support affects around 200,000 people in NW London and can affect any age group[15]. Social isolation is worse for us than well-known risk factors such as obesity and physical inactivity – lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day[16].
- Enabling **children to get the best start in life,** by increasing immunisation rates, tackling childhood obesity and better managing mental health challenges such as conduct disorder. NW London's child obesity rates are higher than London and England - 1 in 5 children aged 4-5 are overweight and obese and at risk of developing LTCs earlier and in greater numbers[13]. Almost 16,000 NW London children are estimated to have severe behavioural problems (conduct disorder) which impacts negatively on their progress and incurs costs across the NHS, social services, education and, later in life, criminal justice system[14].

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A number of cross cutting approaches and new ways of working will support activity in this area and through working across health and social care, with public health leadership will help increase our ability to deliver the interventions and outcomes described below: - **Embedding principles of Making Every Contact Count in all services commissioned across Delivery Areas 1-5** - **Supporting and publicising national campaigns and work such as on cancer prevention, mental health stigma and self care**				
A **Enabling and supporting healthier living – for the population of NWL**	Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices. • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery. • Sign up all NW London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of staff and their ability to support service users.	Together we will jointly implement the healthy living programme plans, supported by NW London and West London Alliance. Local government, working jointly with health partners, will take the lead on delivering key interventions such as: • Introducing measures to reduce alcohol consumption and associated health risks as well as learn from and implement the output from prevention devolution pilots across London • Implement NW London wide programmes for physical activity for adults • Widespread availability of Long Acting Reversible contraception in GP services, maternity and abortion services and early services for early pregnancy loss	3.5	9
B **Keeping People Mentally Well and avoiding Social Isolation**	The healthy living programme plans will also cover how Boroughs will address social isolation, building on current local work: In 16/17, local government already plans to deliver some interventions, such as: • Enabling GPs to refer patients with additional needs to local, non-clinical services, such as employment support provided by the voluntary and community sector through social prescribing • Piloting the 'Age of Loneliness' application in partnership with the voluntary sector, to promote social connectedness and reduce requirements for health and social care services Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems	As part of the Like Minded programme, we will identify isolation earlier and make real a 'no health without mental health' approach through the integration of mental health and physical health support as well as establish partnerships with the voluntary sector that will enable more consistent approaches to services that aim to reduce isolation: • Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes • Ensure all GPs and other health and social care staff are able to direct socially isolated people to support services and wider public services and facilities Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda Provide digitally enabled support to people , including Patient Reported Outcome Measures (PROMs), online communities, digital engagement via online and apps (especially for young people), social prescribing and sign posting to relevant support Providing supported housing for vulnerable people to improve quality of life, independent living and reduce the risk of homelessness. Also explore models to deliver high quality housing in community settings for people with learning disabilities Target smoking cessation activities at people with mental illness to support reducing ill-health as a consequence of tobacco usage.	0.5	6.6
C **Helping children to get the best start in life**	• Implement the prevention priorities within the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services – especially in schools – as part of a wider new model of care • Pilot a whole system approach to the prevention of conduct disorder, through early identification training and positive parenting support, focusing initially on a single borough	• Share learning from the conduct disorder pilot across all 8 CCGs with the aim of replicating success and embed within wider C&YP work • Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity	TBC	TBC

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

The NW London Ambition:

- Everyone in NW London has the same high quality care wherever they live
- Every patient with an LTC has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

Risk of heart attack in a person with diabetes is two to four times higher than in a person without diabetes.

Diabetes accounts for around 10% of the entire NHS spend, of which 80% relates to complications, many of which could be prevented through optimised management. Around 122,000 people are currently diagnosed with diabetes in NW London.

An 11mmol/mol reduction in HbA1c (UKPDS) equates to a reduction of:

- 43% reduction in amputations
- 21% reduction in diabetes related death
- 14% reduction in heart attack

Multifactorial risk reduction (optimising control of HbA1c, BP and lipids) can reduce cardiovascular disease by as much as 75% or 13 events per 1000 person years – this equates to a reduction in diabetes related cardiovascular events of 2806 per year across NW London averaged over a five year period[9].

Why this is <u>important</u> for NW London

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas. Improving the strength and sustainability of primary care is critical in tackling unwarranted variations and improving LTC management and outcomes. Taking action on the key SCF areas of proactive and co-ordination will equip primary care to do so.
- The key focus of this delivery area is the management of long term conditions (LTCs) as 75% of current healthcare spend is on people with LTCs. NW London currently has around 338,000 people living with one or more LTC[1] and 1500 people under 75 die each year from cancer, heart disease and respiratory illness – if we were to reach the national average outcomes, we could save 200 people per year:
  - Over **50%** of cancer patients now survive 10 years or more. There is more we can do to improve the rehab pathways and holistic cancer care[2]
  - **146,000** people (current estimation) have an LTC and a mental health problem, whether the mental health problem is diagnosed or not[3]
  - **317,000** people have a common mental illness and **46%** of these are estimated to have an LTC[4]
  - **512** strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart[5]
  - **198,691** people have hypertension which is diagnosed and controlled – this is around **40%** of the estimated total number of people with hypertension in NW London but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing this to the 66% rate achieved in Canada through a targeted programme would improve care and reduce the risk of stroke and heart attack for 123,383 people

    There are ~20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for underdiagnosis[6]. Best practices (pulmonary rehabilitation, smoking cessation, inhaler technique, flu vaccination) are not applied consistently across care settings
- There is a marked variation in the outcomes for patients across NW London – yet our residents expect, and have a right to expect, that the quality of care should not vary depending on where they live. For example, our breast screening rate varies from 57% to 75% across Boroughs in NW London.
- Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1)[7]. The impact of self-care approaches is estimated to reduce A&E attendances by 17,568 across NW London, a financial impact of £2.4 m[8].
- Children and young people with special education needs and disabilities are a vulnerable group that can require access to specialist support, often delivered by multi-agency services. Implementing CCG responsibilities for SEND under the Children & Families Act 2014 is therefore a NW London priority.

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care. We will do this by:

- Detecting cancer earlier, to improve survival rates. We will increase our bowel screening uptake to 75% by 2020, currently ranging between 40-52%.
- Offering access to expert patient programmes to all people living with or newly diagnosed with an LTC
- Using patient activation measures to help patients take more control over their own care
- Recognising the linkage between LTCs and common mental illness, and ensuring access to IAPT where needed to people living with or newly diagnosed with an LTC
- Using the Right Care data to identify where unwarranted variation exists and targeting a rolling programme across the five years to address key priorities.

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	**Delivering the Strategic Commissioning Framework and Five Year Forward View for Primary Care**	• For Accessible care:
		  • provide extended access specs with quantification of reduced attendances and admissions
		  • Deliver affordable access solutions for the 8-8, 7 day requirements
		  • Create minimum standards for appointment requirements
		  • Achieve accessible read/write patient records
		  • Deliver operational access and a communications programme for patients, key providers and stakeholders
		  • Align extended access provision with urgent care and 111
		• For Co-ordinated care:
		  • define key features for primary and integrated care teams and deliver consistent outcomes for care team models across NW London
		  • Deliver consistent outcomes for care team models across NW London
		  • Agree targeted population within CCG as priority for co-ordinate care management across NWL
		  • Design standard approach to risk stratification and case finding across NWL. Maximise use of WSIC dashboard to monitor patients and case find
		  • Define core intervention for care teams for core population
		  • Define roles that the care team will carry out daily with patients
		• For Proactive care:
		  • finalise key outcome measures for preventive care in LTC
		  • Develop two clinical pathways (including diabetes) and test against provider-models and outcome-measures
		  • Define key outcome measures for needs-based client groups (adults) and explore gap-analysis locally
		  • All eight CCGs supported in implementation of Patient Activation Measure (PAM) programme with target patients receiving PAM assessment and tailored approach to self-care
		• Support CCGs to deliver their GP Access Fund objectives with a consistent and systematic approach, including delivery of the Extended Primary Care Service providing significantly higher levels of access to NW London residents
		• Continue to support the development of federations, enabling the delivery of primary care at scale
		• Host workshops and service-user survey in key geographical areas, building on existing Healthwatch, Patient Participation Group and Lay Partner Advisory Group priorities (e.g. to review I-statements and test outcome measures)
		• Develop two clinical pathways (diabetes, atrial fibrillation) and test against provider-models and outcome-measures
		• Identify four to eight geographical areas to test the draft pathways against the defined outcomes with pilot clinical teams
		• Review of key pressure-points in clinical working day
			• Fully implement the primary care outcomes within the SCF in each of the eight boroughs and across NW London
			• Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working
			• Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers
			• Deliver this range of co-ordinated and population-based care through a system of networked hubs, with facility for both physical and digital access by patients, including services for people with dementia
			• Enable general practices and multi-disciplinary hubs to access and share digital patient records, including crisis care-plans and LTC pathway management
			• Provide access to a spectrum of care, for appropriate population-based interventions for urgent LTC and on-going care needs
			• Ambulatory and emergency care schemes in place
			• Develop relevant LTC clinical pathways in light of co-ordinated and proactive care experience
				18	26.4

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
B C **Improve cancer screening to increase early diagnosis and faster treatment**	Our Primary Care Cancer Board will take the learning from Healthy London Partnership's (HLP) Transforming Cancer Programme to create a strategy for how to improve early detection of cancer, improving referral to treatment and developing integrated care to support people living with and beyond cancer. As part of this we will: • Share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful. • Align our work to HLP's review of diagnostic capacity in 16/17 and work with HLP to develop an improvement plan for 17/18 to ensure sufficient capacity within NW London. • Roll out improved information regarding patient choice and 2 week wait to support patients referred from primary care with suspected cancer • Implement straight to test endoscopy at Imperial, Ealing, Northwick Park and Hillingdon hospitals. • Begin to work with the voluntary sector to research primary care learning from Significant Event Audits • Work with Trusts to create more effective and efficient inter Trust referrals to support the delivery of national standards.	In partnership with Healthy London Partnership' s Transforming Cancer Programme and the Royal Marsden and Partners Cancer Vanguard, we will develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, These actions will reduce variation in acute care and ensure that patients have effective, high quality cancer care wherever they are treated in NW London.	TBC	TBC
D **Better outcomes and support for people with common mental health needs** (with an initial focus on people with long term physical health conditions)	• Improve identification of people with diabetes who may also have depression and/or anxiety and increase their access to IAPT • Improve access to and availability of early intervention mental health services, such as psychosis services, psychological therapies supporting the emotional health of the unemployed and community perinatal services	• Address link between LTCs and Mental Health by specifically addressing impact of co-morbid needs on individuals and the wider system for all residents by 2020/21, delivering joined up physical and psychological therapies for people with LTCs • Ensure at least 25% of people needing to access physiological therapies are able to do so	TBC	TBC

Reduce variation by focusing on 'Right Care' priority areas	• Three key areas identified to be the largest priority to focus on at sector-wide level: diabetes prevention, atrial fibrillation and reducing hypertension
	• Identified and/or commenced work in 2016/17 in following areas:
	  • Mobilisation of National Diabetes Prevention Programme
	  • Comprehensive diabetes performance dashboard at practice and CCG level
	  • Comprehensive referral process for patients with non-diabetic hyperglycaemia into the National Diabetes Programme
	• Aside from these three deliverables, each CCG will be addressing the issues that cause the most unwarranted variation in care in their locality
	• The January 2016 Right Care Commissioning for Value packs showed a £18M opportunity in NW London. A joined up initiative is being launched in NW London to verify the opportunity and identify opportunity areas amenable to a sector wide approach. As a national 1st wave delivery site, Hammersmith & Fulham CCG has identified neurology, respiratory and CVD as priority areas for delivering Right Care. Brent and Harrow have are also national 1st wave delivery sites and are focussing on diabetes and MSK.
		• Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools
		• Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes
		• Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations
		• Joined up working with Public Health team to address wider determinants of health. This will also allow clinicians to refer to services to address social factors
		• Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs
		• Right Care in NW London will bring together the 8 CCGs to ensure alignment, knowledge sharing and delivery at pace. The Programme will ensure the data, tools and methodology from Right Care becomes an enabler and supports existing initiatives such as Transforming Care, Whole Systems Integrated Care and Planned Care within CCGs. The Programme will carry out analysis of available data to identify areas of opportunity as a sector. Deep dive sessions with clinicians and managers to determine the root cause of variation and implement options to maximise value for the system.
			2	12.4

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
Improve self-management and 'patient activation'	• Develop protocols for approved health apps to support self-care in collaboration with Digital Health London • Develop a package of evidence and case studies to support local areas to adopt innovative approaches such as AliveCor, a digital device being rolled out by Hounslow GPs which uses smartphones to detect Atrial Fibrillation in patients Develop best practice approaches to online-management solutions • Host NW London symposium series, commencing with Activating the Workforce in November • Support delivery of IG Governance toolkit L2 compliance within targeted CCG and develop case study for wider support. • Development of Third sector programme framework, supporting development of the voluntary sector infrastructure to support self-care • Patient Activation Measurement (PAM) programme implemented across NW London with target patients receiving assessment and tailored approach to self-care (target 43,920 patients). Self-Care programmes delivered in NW London to be aligned to PAM levels, supporting a tailored approach to self-care and a NW London mental health and wellbeing guidance to PAM levels to be developed.	• Full delivery of Self-Care framework across NW London • NW London workforce supported by embedded self-care training programmes • Technology, including online management solutions, in place to support self-management and health education for people with LTCs • PAM embedded across health and social care supporting tailoring of care for all people with LTC (target 428,700 patients) • Third Sector fully integrated within Accountable Care Partnerships with single point of access and geographically based consortiums • Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be offered access to expert patient programmes • Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time • Pro-active identification of patients by GP practices who would benefit from co-ordinated care and continuity with a named clinician to support them with LTCs • Increase availability of, and access to, personal health budgets, taking on integrated personal commissioning approach, including building on good practice from within and outside NW London around the use of brokerage to manage access to such personalised services	3.4	6.2

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

The NW London Ambition:

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

2020/2021

Contribution to Closing the Financial Gap

£72.1m

Target Population:

311,500

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

- **Over 30% of people in acute hospitals could have their needs met more effectively at home or in another setting**
- **4 in 5 people would prefer to die at home, but only 1 in 5 currently do**
- **17,000 days are spent in hospital beds that could be spent in an individual's own bed**
- **The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary**

Why this is <u>important</u> for NW London

Over the last few years there have been numerous examples of where the NHS and social care have failed older people, with significant harm and even death as a result of poor care. People are not treated with dignity and the increasing medicalisation of care means that it is not recognised when people are in the last phase of life, so they can be subject to often unnecessary treatments and are more likely to die in hospital, even when this is not their wish.

The increase in the older population in NW London poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%[1]
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40%[2] by 2030, which contributes to poor health
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 42.1% of non-elective admissions occur from people 65 and over[4]
- 11,688 over 65s have dementia in NW London which is only going to increase[3]
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

Our aim is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. We will do this by:

- Commissioning services on an outcome basis from accountable care partnerships, using new contracting and commissioning approaches to change the incentives for providers
- Develop plans with partners to significantly expand pooled budgets and joint commissioning for delivery of integrated and out oh hospital care, especially for older people services, to support the development of the local and NW London market
- Increasing the co-ordination of care, with integrated service models that have the GP at the heart
- Increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit
- Identifying when someone is in the last phase of life, and care planning appropriately to best meet their needs and to enable them to die in the place of their choice

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Improve market management and take a whole systems approach to commissioning	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	Implement accountable care partnerships	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnerships • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnerships, with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	Upgraded rapid response and intermediate care services	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible by identifying opportunities and agreeing transformational improvements to NW London models, either locally or NW London-wide • Improve the rate of return on existing services, reducing NEL admissions and reducing length of stay • Enhance integration with other service providers • Establish an older people's reference group to guide this work • Agreed the older person's pathway across community, acute and last phase of life • Agreed areas for standardisation across NW London for IC/RR and acute frailty • Agreed outcomes and standards for intermediate care function and acute frailty	• Use best practice model across all eight boroughs, creating standardisation wherever possible to enable additional capacity to decrease the inappropriate time that a person is cared for in an institutional setting • Operate rapid response and integrated care as part of a fully integrated ACP model	20.2	64.9
D	Create an integrated and consistent transfer of care approach across NW London	• Agree an integrated health and social care model to improve transfer of care • Implement a single needs-based assessment to support appropriate transfer of care via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and transfer of care across NW London	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • Transfer of care correspondence is electronic with the single assessment process built into the shared care records across NW London • Fully integrated health and social care transfer of care process for all patients in NW London	7.4	9.6
E	Improve care in the last phase of life	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

The NW London Ambition:

No health without mental health

2020/2021

Target Population:

262,000

Contribution to Closing the Financial Gap

£11.8m

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My life is important, I am part of my community and I have opportunity, choice and control. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing. My care is seamless across different services, and in the most appropriate setting. I feel valued and supported to stay well throughout my life.

Why this is important for NW London

Mental Health has been seen in a silo for too long and has struggled to achieve parity of esteem. The NW London STP has mental health threaded throughout our delivery areas – within prevention and within work on long term conditions. But we know that focus is also required as poor mental health has catastrophic impacts for individuals – and also a wider social impact. Our justice system, police stations, courts and prisons all are impacted by mental illness. Social care supports much of the care and financial burden for those with serious and long term mental health needs, providing longer term accommodation for people who cannot live alone. For those off work and claiming incapacity benefit for two years or more, they are more likely to retire or die than ever return to work[1]. The '5 Year forward View for Mental Health' describes how prevention, reducing stigma and early intervention are critical to reduce this impact – and the outcomes described in the implementation guidance are reflected in our plans[2].

In NW London, some of the key drivers and our case for change are:

- **15% of people** who experience an episode of psychosis will experience repeated relapses and will be substantially impacted by their condition and **10% will commit suicide**
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly **90% of inpatient bed days, and 80% of spend in mental health trusts**.
- Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before the age of 18 .
- Around **23,000 people in NW London** have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- The population with mental illness have **3.2 times more A&E attendances, 4.9 times emergency admissions**
- The contrast with physical health services is sharp and stark – thresholds to access services can be barriers to access care – and stigma remains a challenge for many people – and in particular within some communities,

Our aim in NW London is to improve outcomes for children and for adults with mental health needs, we will do this by:

- Implementing a new model of care for adults which includes investing in a more proactive, recovery based model to prevent care needs from escalating and reducing the number of people who need inpatient acute care
- Addressing the very specific needs that relate to some of our populations – such as for people with learning disabilities (through the Transforming Care Partnership) and for new mothers
- Improving services for people in crisis and providing a single point of access to services, 24/7, so that people can access the professional support they need – building on current Early Intervention in Psychosis and Liaison Psychiatry services.
- Implementing 'Future in Mind' Transforming the care pathway for children and adolescents with mental health needs, introducing a 'tier free' model and ensuring that when children do need to be admitted to specialist tier 4 services they are able to do so within London, close to home[3].

- People with serious and long term mental health needs have a life expectancy 20 years less than the average
- Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation
- In a crisis, only 14% of adults surveyed nationally felt they were provided with the right response
- Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	**Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy**	• More support available in primary care through locally commissioned services – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training
		• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes
		• Agree investment and benefits to deliver an NW London wide Model of Care for Serious & Long Term Mental Health Needs with implementation starting in 2016/17 to deliver a long term sustainable mental health system through early support in the community
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
		• More support available in primary care through locally commissioned services
			• Full roll out of the new model across NW London providing tailored evidence based support available closer to home to service users and carers, which will include:
			  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support
			  • Comprehensive self management and peer support for all ages
			  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation
			  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community
			 
				11	16

B	**Focussed interventions for target populations**	• Targeted employment services for people with serious and long term health needs to support maintaining employment • Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs • Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach • Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams • Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements	• Provide vulnerable individuals and their families with best practice support • Employment support embedded in integrated community teams • Deliver the NW London Transforming Care Plan for people with Learning Disabilities, Autism and challenging behaviour – supporting c.25% of current inpatients in community settings • Implement digital tools to support people in managing their mental health issues outside traditional care models • Specialist community perinatal treatment available to all maternity and paediatric services and children centres • Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care	TBC	5

C	**Crisis support services, including delivering the 'Crisis Care Concordat'**	• Embed our 24/7 crisis support service, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS), Metropolitan police and other services – meeting access targets
		• Round the clock mental health teams in our A&Es and support on wards, progress towards 'core 24'
		• Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)
			• Ensure care will be available for service users and carers when they most need it through:
			  • Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery
			  • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis
				TBC	TBC

D	**Implementing 'Future in Mind' to improve children's mental health and wellbeing**	• Agree NW London offer across health, social care and schools for a 'tier-free' mental health and wellbeing approach for CYP, reducing barriers to access • Community eating disorders services for children and young people	• Implement 'tier-free' approach ensuring an additional c.2,600 children receive support in NW London • Digital enablement to share information between care settings to support new care models • Clearly detailed pathways with partners in the Metropolitan Police and wider justice system for young offending team, court diversion , police liaison and ensure optimal usage of refurbished HBPOs (8 across NW London)	TBC	1.8

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

The NW London Ambition:

High quality specialist services at the time you need them

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

2020/2021

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

Why this is important for NW London

Medicine has evolved beyond comprehension since the birth of the NHS in 1948. Diseases that killed thousands of people have been eradicated or have limited effects; drugs can manage diabetes, high blood pressure and mental health conditions, and early access to specialist care can not just save people who have had heart attacks, strokes or suffered major trauma but can return them to health. Heart transplants, robotic surgery and genetic medicine are among advances that have revolutionised healthcare and driven the increasing life expectancy that we now enjoy.

Better outcomes are driven in large part by increasing standards within medicine, with explicit quality standards set by the Royal Colleges and at London level in many areas. These require increased consultant input and oversight to ensure consistent, high quality care. Current standards include consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. Meeting these input standards are placing significant strain on the workforce and the finances of health services. We will continue to work with London Clinical Senate and others to evolve clinical standards that strikes a balance between the need to improve quality, as well address financial and workforce challenges. Many services are only available five days a week, and there are 10 seven day services standards that must be met by 2020, further increasing pressures on limited resources.

- In NW London A&E departments, 65% of people present in their home borough but 88% are seen within NW London. The cross borough nature of acute services means that it is critical for us to work together at scale to ensure consistency and quality across NW London[2]
- 3 out of our 4 Acute Trusts with A&Es do not meet the A&E 4 hour target[3]
- Our 4 non specialist acute trusts all have deficits, two of which are significant
- There is a shortage of specialist children's doctors and nurses to staff rotas in our units in a safe and sustainable way (at the start of 16/17) [4]
- 17/18 year olds currently do not have the option of being treated in a children's ward
- Previous consolidations of major trauma and stroke services were estimated to have saved 58 and 100 lives per year respectively[5]
- Around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[6]
- There are on average at any one time 298 patients in beds waiting longer than 24 hours for diagnostic tests or results. [7]

We aim to centralise and specialise care in hospital to allow us to make best use of our specialist staffing resource to deliver higher quality care which will improve outcomes, deliver the quality standards and enable us to deliver consistent services 7 days a week. We will do this by:

- Reviewing care pathways into specialist commissioning services, identifying opportunities to intervene earlier to reduce the need for services
- Deliver the 7 day standards
- Ensure all patients receive prompt treatment in accordance with the national referral to treatment (RTT) standards,
- Consolidate acute services onto five sites (the local government position on proposed acute changes is set out in Appendix A)
- Improve the productivity and efficiency of our hospitals.

There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Specialised Commissioning**	• Implement the national Hepatitis C programme which will see approximately 500 people treated for Hepatitis C infection in 2016/17 reducing the likelihood of liver disease. • Complete our service reviews of CAMHs, HIV, paediatric transport and neuro-rehabilitation and begin to implement the findings from these and identify our next suit of review work (which will include renal). • Using the levers of CQUIN and QIPP improve efficiency and quality of care for patients through a focus on: innovation (increasing tele-medicine), improved bed utilisation by implementing Clinical Utilisation Review and initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • Be an active partner in the 'Like Minded' Programme	To have worked with partners in NW London and strategically across London to: • Identify the opportunities for better patient care, and greater efficiency by service such that quality, outcomes and cost-effectiveness are equal or better than similar services in other regions. • To have met the financial gap we have identified of £188m over five years on a 'do nothing' assessment; whether through pathway improvements, disease prevention, innovation leading to more cost effective provision or through procurement and consolidation. • To actively participate in planning and transformation work in NW London and Regionally to this end	TBC	TBC
B	**Deliver the 7 day services standards**	As a First Wave Delivery Site, working towards delivering the 4 prioritised Clinical Standards for 100% of the population in NW London by end of 16/17; we will: • develop evidence-based clinical model of care to ensure: - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital - on-going review by consultant every 24 hours of patients on general wards • ensure access to diagnostics 7 days a week with results/reports completed within 24 hours of request through new/improved technology and development of career framework for radiographer staff and recruitment campaign • ensure access to consultant directed interventions 7 days a week through robust pathways for inpatient access to interventions (at least 73) in place 24 hours a day, 7 days a week	To have continued our work on 7 day services by being compliant with the remaining 6 Clinical Standards for 100% of the population in NW London: • Patient Experience • MDT Review • Shift Handover • Mental Health • Transfer to community, primary & social care • Quality Improvement We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will: • Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network • Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care • Deliver NW London workforce initiatives such as a sector-wide bank, joint recruitment & networked working	7.9	21.5

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C **Configuring acute services**	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units Working to achieve London Quality Standards, including consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. But at the same time developed new outcome-focused standards with London Clinical Senate and others. Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016 Design and implement new frailty services at the front end of A&Es, piloting in Ealing and Charing Cross ahead of roll out across all sites Fully deliver on the vision for maternity set out in *Better Births* national maternity review – through our 15/16 reconfiguration programme we have already made significant progress delivering this vision for maternity. In 16/17 we will focus on providing continuity of care for women, so that maternity care is provided by a small team of midwives during the antenatal, intrapartum and postnatal period.	Reduce demand for acute services through investment in the pro active out of hospital care model, enabled by investment in the Hubs. Develop the hospital in Ealing and jointly shape the delivery of health and social care provision of services from that site, including: • a network of ambulatory care pathways • a centre of excellence for elderly services including access to appropriate beds • an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs Revolutionise the outpatient model by using technology to reduce the number of face to face outpatient consultations by up to 40% and integrating primary care with access to specialists. Deliver on the full recommendations set out in *Better Births* national maternity review, in order to achieve joined-up, sustainable continuity of care for women in NW London.	33.6	89.6
D **NW London Productivity Programme**	A Chief Transformation Officer has been appointed to lead a collaborative transformation programme across all NHS Trusts in NW London and a team of interim senior programme directors have been appointed. By the end of 16/17 we will agree and resource a sustainable team to ensure these priorities are delivered. This is a big ticket cost reduction transformation programme within the STP and we should secure investment proportionate to the costs savings. Implement and embed the NW London productivity programme across all provider NHS trusts, focusing on the following four areas: • **Orthopaedics**: mobilise a sector-wide approach to elective orthopaedics with the goal of improving both quality and productivity in line with Getting it Right First Time (GIRFT) to reduce unwarranted variation and increase efficiency, thus generating both quality improvements and financial savings. Ensure all Acute Providers in North West London have agreed Best In Sector Performance Metrics and establish a NW London dashboard. Agree priorities and interventions and commence delivery. • **Procurement**: deliver £3m of immediate tactical non-pay savings. Agree plan to reduce unwarranted variation in NHS supplies prices, and make £15.2m savings in non-pay spend. Develop options and agree a NW London operating model, in line with best practice and Carter and identify any structural changes required to the way procurement is currently delivered. , Establish common procurement competencies and staff development plan. Ensure robust plans in place with ownership from Procurement leads, CFOs and clinical lead and identify any investment required. • **Safer Staffing**: Agree a three year delivery plan with trajectory of benefits and any required investment identified. Agree detailed proposal for reduction in agency costs via more effective staff bank, supported by technology. All e-nursing rosters agreed six weeks in advance and plan for medical roster implementation, benchmark and share all data. • **Back Office**: this is **new and additional priority** agreed in September 2016. Deliver additional collaborative productivity opportunities. Agree priorities, geographic clusters and three year delivery plan with trajectory of benefits and any required investment identified. Integrated Procurement and Safer Staffing work within the wider Back Office plans.	Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together to deliver added value. **Rolling programme of pathway redesign and quality improvement initiatives to ensure trusts are consistently in the top quartile of efficiency (Getting It Right First Time principles).** Shared records is a key enabler of all pathway redesign. • **Orthopaedics:** Implement plan agreed in 16/17. Agree a consolidated service model for a NWL collaborative elective Orthopaedic centre, agree a business case and implement subject to investment. • **Identify and implement priorities for rolling programme following Orthopaedics.** • **Procurement:** Implement a pan-NWL procurement operating model which is compliant with the National Interim Future Operating Model, Deliver Carter compliant Procurement Transformation Plans with quantified (and delivered) financial savings which all leads to Collaborative and shared service models in place for NWL procurement operating within a sustainable financial footprint assessed by improving year on year saving: cost ratios. • **Safer Staffing:** build on work from 2016/17 such that rostering is optimised, bank fill rates are maximised and reliance on agency is minimised. (quantified benefits will emerge from 16/17 business case) Developed a workforce plan summarising the total workforce numbers and competencies required across NWL. Collective workforce planning and collaborative resourcing to include recruitment, development and retention with the right balance of permanent and flexible workers . • **Back Office**: Implement priorities as described in business case.	4.1*	143.4

3. Enablers:
Supporting the 5 delivery areas

The 9 priorities, and therefore the 5 delivery areas, are supported by three key enablers. These are areas of work that are on-going to overcome key challenges that NW London Health and Social Care face, and will support the delivery of the STP plans to make them effective, efficient and delivered on time; hence they are termed 'enablers' in the context of STP. The following mapping gives an overview of how plans around each of the enablers support the STP: further detail is provided in the next section.

Delivery areas

1. Radically upgrading prevention and wellbeing
2. Eliminating unwarranted variation and improving Long Term Conditions (LTC) management
3. Achieving better outcomes and experiences for older people
4. Improving outcomes for children and adults with mental health needs
5. Ensuring we have safe, high quality sustainable acute services

By 2020/21, Enablers will change the landscape for health and social care:

Estates will…

- Deliver **Local Services Hubs** to enable more services to be delivered in a community setting and support the delivery of primary care at scale
- Increase the use of advanced technology to **reduce the reliance on physical estate**
- Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate'
- Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants
- **Improve and change our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care

Digital will…

- **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality
- **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital
- **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care
- **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care
- **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence

Workforce will…

- **Target recruitment** of staff through system wide collaboration
- Support the workforce to enable 7 day working through **career development and retention**
- **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning
- Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working**
- Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly)
- Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing

3. Enablers: Estates

Context

The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.

Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings

Our model requires investment in the development of local hubs to enable the provision of integrated, co-located health care, social care and voluntary support across the eight local authority/CCG areas, reducing A&E and UCC attendances and providing accessible, pro-active and coordinated care.

NW London has developed and submitted a joint 'One Public Estate' bid to leverage available estate to deliver the right services in the right place, at the most efficient cost. Key levers to achieve this are better integration and customer focused services enabling patients to access more services in one location, thus reducing running costs by avoiding duplication through co-location. We are keen to explore this as an early devolution opportunity.

A joint health and council estates group has been established to oversee the work and minimise gross spend through aligning health and local authority plans for regeneration and seeking innovative financial solutions to provide estate cost-effectively, realising value from surplus assets.

There has been significant local progress towards estates integration, where local government and health have worked together to start to realise efficiencies. A notable example is in Harrow's new civic centre, where it is planned that primary care will be delivered at the heart of the community in a fit for purpose site alongside social care and third sector services. This will also enable the disposal of inadequate health and local government sites to maximise the value of public sector assets.

Key Challenges

- NW London has more poor quality estate and a higher level of backlog maintenance across its hospital sites than any other sector in London. The total backlog maintenance cost across all Acute sites in NWL (non-risk adjusted) is £614m[1] and 20% of services are still provided out of 19th century accommodation[2], compromising both the quality and efficiency of care.
- Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below estate[3]. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014[4], but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand, driving increased pressure on UCC and A&E departments.
- Our new proactive, integrated care model will need local hubs where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centred services. This will also allow more services to be delivered outside of hospital settings.
- In addition, NHS Trusts are responding to the Government's decision to act on the recommendations made by Lord Carter in his report of operational productivity in English NHS acute hospitals, to reduce non-clinical space (% of floor area) to lower than 35% by 2020, so that estates and facilities resources are used in a cost effective manner.
- Given the scale of transformation and the historic estates problems, there is significant investment required. However it is not clear if the London devolution agreement will support the retention of capital receipts from the sale of assets to contribute to covering the cost of delivering the change. Without this ability to retain land receipts we will not be able to address the estates challenges.

3. Enablers: Estates

Current Transformation Plans and Benefits

- **Deliver Local Services Hubs** to support shift of services from a hospital setting to a community based location
  - Business cases are being developed for each of the new Hubs
  - The hub strategy and plans include community Mental Health services, such as IAPT
  - Hubs will support delivery of the GP 5 Year Forward View and are critical in enabling reconfiguration of acute services
  - Hubs will also help deliver the access and coordinated care aspects of the Strategic Commissioning Framework
- **Develop Estates Strategies for all 8 CCGs and Boroughs** to support delivery of the Five Year Forward Plan and 'One Public Estate' vision with the aim of using assets more effectively to support programmes of major service transformation and local economic growth
  - Work is on-going to develop planning documents for delivery of the strategies
  - Continuing work with local authority partners to maximise the contribution of Section 106 and Community Infrastructure Levy funding for health
- **Develop Primary Care Premises Investment Plans** to ensure future sustainability of primary care provision across NW London
  - NW London will identify key areas to target investment to ensure future primary care delivery in partnership with NHSE primary care teams
  - CQC and other quality data is being used to identify potential hot spots in each Borough and develop robust plans to ensure a sustainable provision of primary care
- **Align Estates and Technology Strategies** to maximise the impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation
  - NW London will optimise property costs by maximising use of existing space, eradicating voids and using technology to reduce physical infrastructure required for service delivery
  - Continuing work to identify opportunities for consolidation, co-location and integration to maximise the opportunity created by the Estates & Technology Transformation Fund to drive improvements in the quality of the primary care estate
- **Improving and changing the hospital estate** to address poor quality estates, improve consistency in care quality and overall system sustainability in the face of increasing demographic and clinical pressures
  - Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local Population
  - Trusts have developed proposals with the resultant capital requirement being presented in the Shaping a Healthier Future business case which is due to go to the NHSE investment committee for approval

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:

- Local services hubs will provide the physical location to support integrated public health, prevention and out-of-hospital care delivered by health , social care and voluntary organisations.
- Investment in the primary care estate will provide locations where health, social care, and voluntary providers can deliver targeted programmes to tackle lifestyle factors and improve health outcomes,

Delivery Area 2 - Reducing variation:

Local services hubs will support the implementation of a new model of local services across NW London. This will standardise service users' experiences and quality of care regardless of where they live, delivering 7 day access to all residents

Delivery Area 3 - Outcomes for older people:

- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management of the frail elderly, with the ability to manage higher levels of need and the provision of appropriate bedded care

Delivery Area 4 - Supporting those with mental health needs:

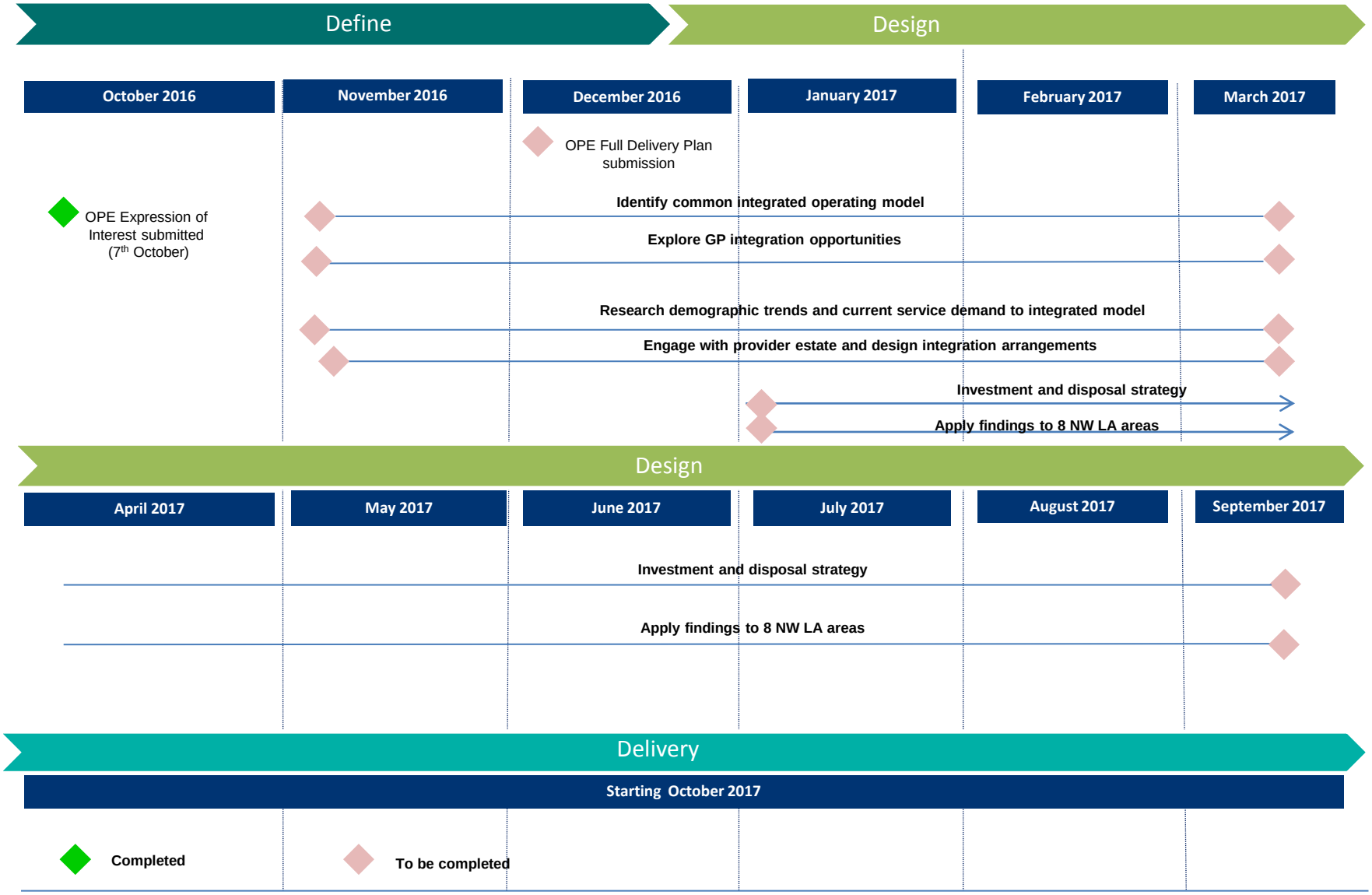
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting model of care

Delivery Area 5 – Providing high quality, sustainable acute services:

- Addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity
- Increasing the capacity of the major acute sites will enable consolidation of services, driving improved outcomes and longer term clinical and financial sustainability
- Enhanced primary and community capacity will support delivery of the vision of a new proactive care model and reduce pressure on major acute sites

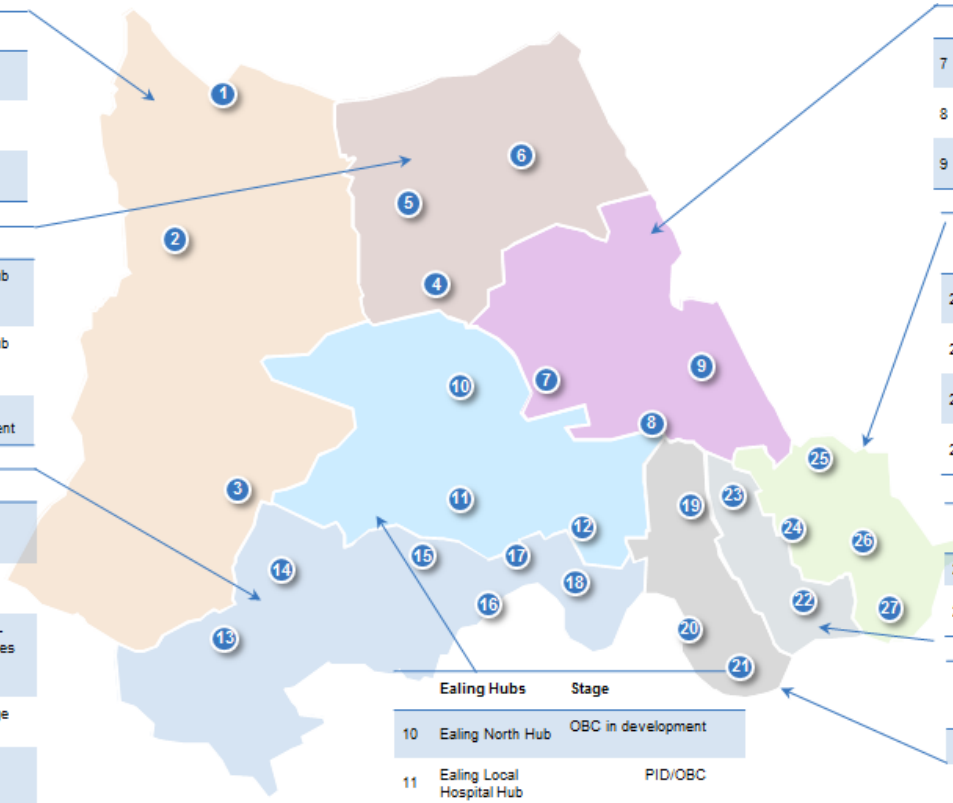
3. Enablers:
Estates

Estates Strategy to deliver Out of Hospital through One Public Estate (OPE) – High level timeline to Oct 2017



3. Enablers:
Estates

Proposed Local Services Hubs map



	Hillingdon Hubs	Stage
1	North Hillingdon Hub	Strategic stage (pre-PID)
2	Uxbridge and West Drayton Hub	Strategic stage (pre-PID)
3	Hesa Primary Care Centre	Operational

	Harrow Hubs	Stage
4	The Pinn Medical Centre	Existing hub – adding services
5	Alexandra Avenue Health and Social Care Centre	Existing hub – adding services
6	NE Harrow	OBC in development

	Hounslow Hubs	Stage
13	Feltham Health Centre	Operational
14	Heston Health Centre	OBC in development
15	Heart of Hounslow Centre for Health	Existing hub – adding services
16	West Middlesex Hospital Hub	Strategic stage (pre-PID)
17	Brentford Health Centre	Operational
18	Chiswick Health Centre	Operational

	Ealing Hubs	Stage
10	Ealing North Hub	OBC in development
11	Ealing Local Hospital Hub	PID/OBC
12	Ealing East Hub	OBC in development

	Brent Hubs	Stage
7	Wembley Centre for Health and Care	OBC in development
8	Central Middlesex Hospital 'Hub Plus'	OBC in development
9	Willesden Centre for Health and Care	Strategic stage (pre-PID)

	Central London Hubs	Stage
24	St Mary's Hospital Hub	SOC in development
25	Church Street Hub	OBC in development
26	Central Hub Moxon Street	Strategic stage (pre-PID)
27	South Westminster	Operational

	West London Hubs	Stage
23	St Charles Centre	OBC in development
22	South Locality Hub	OBC in development

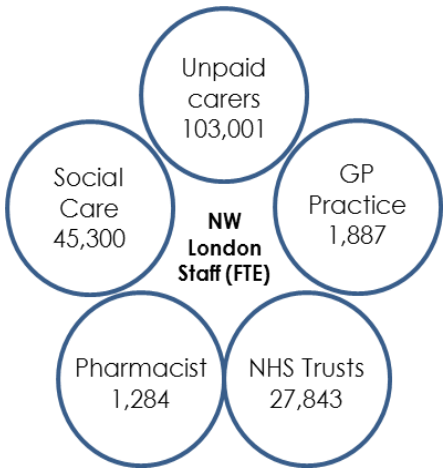
	Hammersmith & Fulham Hubs	Stage
19	Park View (formerly known as White City)	Operational
20	Charing Cross Hospital Hub	Pre OBC in development
21	Parsons Green	OBC in development

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work. It will also be key to achieving our collective vision of improved quality of care through delivering sustainable new models of care that meet our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly to expand work across social care[1].
- Carers are also a large, hidden but integral part of our workforce (NW London has more than 100,000 unpaid carers). Supporting and enabling service users to self-manage their conditions will also be crucial to achieving our vision.
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Appropriate workforce planning and actively addressing workforce issues will, however, be instrumental in addressing the five delivery areas in the STP.

The NW London workforce



The challenges our workforce strategy will address to meet the 2020 vision:

Addressing workforce shortages

- Workforce shortages are expected in many professions under the current supply assumptions and increases are expected in service demand, therefore current ways of service delivery must change and the workforce must adapt accordingly. Addressing shortages and supporting our workforce to work in new ways to deliver services is fundamental to patient care.

Improving recruitment and retention

Modelling undertaken by London Economics in relation to Adult Nursing indicated that across London, over the next 10 years, the impact of retaining newly qualified staff for an additional 12 months could result in a saving of £100.7 million[2].

- **Turnover rates within NW London's trusts** have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing &15% medical[3].
- **Vacancy rates** in social care organisations are high. The majority of staff in this sector are care workers, they have an estimated vacancy rate of 22.4%. **Disparity in pay** is also an issue (e.g. lower in nursing homes)[4].
- High **turnover of GPs** is anticipated; NW London has a higher proportion of GPs over 55 compared to London and the rest of England (28% of GPs and almost 40% of Nurses are aged 55+)[5]

Workforce Transformation to support new ways of working

- There will be a 50% reduction in workforce development funding for staff in Trusts, however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.

Leadership & Org. Development to support services

- Delivering change at scale and pace will require new **ways of working**, **strong leadership** and over arching change management. ACPs and GP Federations will be the frameworks to support service change, through shared ownership and responsibility for cost and quality.
- Wide scale **culture change** will require changes in the way organisations are led and managed, and how staff are incentivised and rewarded.

3. Enablers: Workforce

Achievements to date

Workforce planning and addressing workforce shortages

- Developed Infrastructure for workforce planning and analytics
- Established annual workforce planning processes for acute healthcare professionals
- Extended workforce planning to cover primary care including new models of care such as the Cancer Vanguard
- Worked with Skills for Care and engaged with national project work to ensure integrated workforce planning for Social Care
- Invested in a team of 4 workforce planners to support primary care and integration. Work includes the Day of Care Audit designed to improve efficiency in General Practice
- Worked with the Healthy London Partnership to understand the demand and supply of staff in primary care and identified opportunities to close the gaps.
- Led a centralised Pan-London placement management and workforce development programme for paramedics with an investment of over £1.5m, contributing to increasing workforce supply and staff retention
- Utilised health education funding to ensure high quality education for medical trainees is on-going.

Improving recruitment and retention

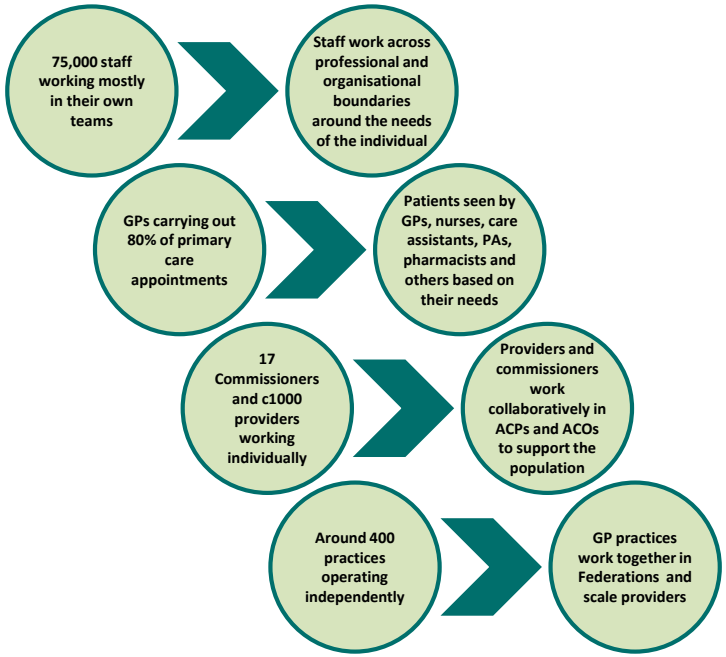
- With Capital Nurse we have started recruitment of 350 newly qualified nurses onto a rotational programme with educational and development support, this covers all NHS trusts in NW London as well as primary care. This investment will demonstrate the benefits of a rotational programme in improving retention rates and developing nurses within NW London to move on from their training to more senior nursing posts.
- We have programmes to improve the recruitment of nurses in general practice including a funded course with placements for nurse from outside of practice nursing to develop skills and experience to move into the sector. In 16/17 we have recruited 26 nurses across NW London.
- Through close working with HEE NW London we have supported the workforce whilst implementing service change in primary, integrated and acute care. Nine physician associates currently work in NW London, 31started training in September, a further 15 will start in February 2017. Through our development of clinical networks for maternity and children's services we have redesigned the model of care and formulated sector wide recruitment strategies that have enabled us to recruit 99 more midwives, 3 more obstetricians, 95 paediatric nurses and 9 consultants paediatricians.

Governance

Governance has been improved to deliver a comprehensive STP workforce strategy. This is supported by a strengthened collaboration between Health Education England and the CCG collaborative, local councils and other stakeholders. A CCG and HEE joint STP workforce team reports to a newly established Board that is co-chaired by the CCG, Social Care and HEE is a **key enabler** to delivery. This approach encompasses critical experience and expertise. It also maximises efficiency and ensures clinically led decision making and input from key stakeholders including health and social care providers, CEPNs (Community Education Providers Network) and the Healthy London Partnership.

A new robust governance structure to deliver the STP workforce strategy

What will be different in 2020[6]?



3. Enablers: Workforce

Current Transformation Plans and Benefits

Workforce planning and addressing workforce shortages

Effective workforce planning is essential for securing our future workforce, it underpins all further interventional activity and investment to support the workforce. We have the infrastructure in place to forecast shortages and develop plans to address them. This includes Primary Care and work is underway to ensure it covers new models of care such as the Cancer Vanguard. Critically this work will also include social care working with Skills for Care and through engagement and national project work.

Improving recruitment and retention

Improving recruitment and retention across health and social care will be critical to closing the financial gap and addressing workforce shortages. Modelling in London and the south east shows £100.7 million could be saved in the next 10 years by retaining new staff for 1 extra year. Recruitment and retention issues lead to high use of agency staff costing £172m.

To reduce spend on agency we will control demand for bank shifts by improving rostering and encourage more staff to work through banks instead of agencies to reduce agency costs.

Delivering the improvements in CAMHS Eating Disorder services will require an increase in numbers of staff with these specialist skills , we know we will face competition for these staff. We will work with our Like Minded programme to make sure NW London is an attractive place to come and work to retain current staff and improve recruitment

Workforce Transformation across health and social care workforce to support integrated care

Care in NW London will be delivered differently in 2021. Building on existing work we will support staff to work in new ways. To deliver the Strategic Commissioning Framework and the 10 point plan for Primary Care we will support workforce to improve productivity and build capacity in general practice and develop the whole care team. We will work with the Time for Care programme at an NW London level and develop local CCG plans based on local priorities and areas where the 10 High Impact Actions will have the greatest effect.

We have established the Change Academy. This is a collaborative programme across NW London to address workforce transformation, organisational development between providers and systems leadership. Through Change Academy High Performing Care programme we will support system change through high performing teams and improvement methodology underpinned by data enabled evidence-based decision-making. The scope of this programme will be multi-organisational change teams charged with delivery of STP on actual delivery issues in real time.

Leadership and Organisational Development to support future services

We understand that effective leadership underpins the transformation we need to achieve in NW London. As part of the Change Academy there are programmes targeted at supporting leaders across health and care:

I. STP/SPG systems leadership

II. Joint commissioning skills development

III. Emerging GP leaders network

IV. Practice manager development programme

This work will support staff and carers across all settings through the changes required by the STP and to develop the right culture to make sure changes are successfully delivered.

Key Impacts on Sustainability & Transformation Planning

NW London will deliver some general transformation plans that tackle the challenges faced and underpin all delivery areas to :

- Embed **new roles and develop career pathways** to support a system where more people want to work and are able to broaden their roles
- **Empower** MDT frontline **practitioners to lead** and engage other professionals and take joint **accountability across services**
- **Support staff** through change through training and support

Delivery Area 1 – Prevention and self management:

- Using **£1.5m HEE funding** to support new models of care, self-care and LTCs
- Train up to 180 health and care professionals **to support self-care**
- Supporting 24 professionals to become **health coach trainers** to enable patients to take greater responsibility for their health
- Expand the programme in 2017/18 to develop carers as health trainers.
- Embed the NW London **Healthy Workplace Charter** to promote staff health and wellbeing initiatives and ambassadorship

Delivery Area 2 - Reducing variation:

- The seven day services programme is receiving an additional investment of £750K to trial new models of care and to further support the Radiography workforce.
- The Cancer Vanguard is being supported through instigating new project leads to drive evidence based service design

Delivery Area 3 - Outcomes for older people:

- Initiatives to attract and retain staff to work in integrated MDTs and new local services models will support the frail and elderly population. E.g: Scale recruitment drives, promoting careers in primary care through training placements and skills exchange across different care settings
- Delivery of the SCF and 10-pont plan for Primary Care through workforce transformation
- Consultant outreach into primary care
- CEPNs focused on developing the primary care and community workforce
- Building on the work of the early adopters

Delivery Area 4 - Supporting those with mental health needs:

- GPs provided with tools, time and support to better support population with serious and long term mental health needs. 35 GPs were supported through an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.
- Using £600k of HEE funding to support the transformation of Serious and long term mental health and children and young people's mental health

Delivery Area 5 – Providing high quality, sustainable services:

- The **Streamlining London Programme** ; a pan-London provider group to achieve economies of scale by doing things once across London
- Reduce the reliance on agency nurses by improving recruitment and more effective rostering and thereby the cost of service

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London CCGs, with good progress with Information Governance across care settings.
- Each of the eight CCGs has a single IT system across their practices, and six of the eight CCGs are implementing common systems across primary and community care.
- In the acute space, Imperial and Chelsea & Westminster have a strong track record with digital clinical systems and are working together on a common Electronic Patient Record. Imperial (with Chelwest) is expected to be nominated by NHS England as a Global Digital Exemplar and will provide leadership to the rest of the footprint in the provision of improved patient outcomes and enhanced business efficiencies.
- Digital technology will support Primary Care transformation with new models of care that support out of hospital Local Services, through shared records across care settings, including new GP provider networks/hubs and ultimately via Accountable Care Partnerships. Potential funding from the Estates & Technology Transformation Fund (ETTF) will help upskill the primary care workforce and encourage patients to use new digital channels to access care, and use digital tools to become more involved in their own care.
- The footprint has a good track record in delivery of shared records, e.g. the NW London Diagnostic Cloud. The NW London Care Information Exchange is under way, funded by the Imperial College Healthcare charity, to give patients and clinicians a single view of care across providers and platforms, and provide tools to improve communication with health and social care professionals. It has been integrated with acute Trust data but is currently constrained by the lack of interfaces with EMIS and SystmOne in primary and community care. In the longer term, it is our ambition for the NWL Exchange to interface with the wider London Health and Care Information Exchange.
- There is good support from the NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London information exchange, record locator, and IG register.
- Imperial College Health Partners (ICHP), Academic Health Science Network (AHSN) for NW London, is working closely with local health and care partners to ensure that innovation plays a major part in achieving the goals set out in our STP. One example of this is the roll-out of the Intrapreneur programme which to date has enabled over 100 local executives and frontline clinicians to integrate innovation with their everyday role.

Key Challenges

- There is a significant challenge for digital to transform current delivery models and enable new, integrated models of health and social care, shifting care out of hospitals through shared information between care settings and a reduced emphasis on traditional face-to-face care delivery.
- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access information about the patient[1]. This will be mitigated by sharing care records and converging with other footprints via national and pan-London NHS systems and capabilities (e.g. Summary Care Record, e-Referrals, Co-ordinate My Care, electronic discharges); and in the longer term addressed through the NW London Care Information Exchange and (for the 16% outside the footprint) a pan-London information exchange.
- Due to different services running multiple systems, achieving shared records is dependent on open interfaces, which primary and community IT suppliers have not yet delivered. This will require continued pressure on suppliers to resolve – in particular TPP and EMIS.
- There is a barrier to sharing information between health and social care systems due to a lack of open interfaces. This has led to a situation where social care IT suppliers have been looking to charge councils separately. Support is requested from NHSE to define and fund interfaces nationally.
- Clinical transformation projects are invariably costly and time consuming, which needs to be allowed for in the LDR plans
- Some citizens and care professionals have rising expectations for digital healthcare which we cannot deliver; for others, there is a lack of digital awareness and enthusiasm, requiring a greater push for communication around the benefits of digital solutions and education on how best to use them.

Strategic Local Digital Roadmap (LDR) Vision in response to STP

1. **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality
2. **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital
3. **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care
4. **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care
5. **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence

Enabling work streams identified:

- **IT Infrastructure** to support the required technology, especially networking (fixed line and Wi-Fi) and mobile working
- **Completion of the NW London IG framework**
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education.
- **Digital Health** to leverage innovations such as remote monitoring, point of care and self-testing, mobile applications, interoperability of IT systems, big data analytics and AI.

The NW London Digital Programme Board will oversee delivery of the LDR, integrated with the governance of the STP.

3. Enablers: Digital

STP Delivery Area	LDR Work Stream	Key Digital Enablers for Sustainability & Transformation Plan
1. Radically upgrading prevention and wellbeing	• Tools for self-management and self-care • Enable Patient Access • Build a shared care record	**Deliver digital empowerment to enhance self-care and wellbeing:** • Easier access for citizens to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • Innovation programme to find the right **digital tools** to: help people **manage their health and** wellbeing through digital apps of their choice, connected to clinical IT systems; **create online communities** of patients and carers; get children and young people involved in health and wellness • **New digital channels** (e.g. online and video consultations) to help people engage more quickly and easily with primary care **Embed prevention and wellbeing into the 'whole systems' model:** • Support for integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care plans that are shared with patients and carers)
2. Eliminating unwarranted variation and improving LTC management	• Automate clinical workflows and records • Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Deliver digital empowerment by increasing patient engagement to better self-manage their LTCs:** • Delivery of Patient Activation Measures (PAM) tool for every patient with an LTC to develop health literacy and informed patients • Innovation programme to help people **manage their LTCs (conditions and interventions)** through digital apps of their choice, extending clinical systems to involve patients (e.g. SystmOne for diabetes) and potentially telehealth (e.g. wearable technology) **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience • Support for new models of multi-disciplinary care, delivered consistently across localities, through shared care records • **Automation of clinical workflows and records**, particularly in secondary care settings, and support for new pathways and transfers of care through interoperability and development of a shared care record to deliver **integrated health and care records and plans**
3. Achieving better outcomes and experiences for older people	• Enable Patient Access • Build a shared care record • Use dynamic data analytics	**Provide fully integrated service delivery of care for older people** • **Shared clinical information and infrastructure** to support new primary care and wellbeing hubs and ACPs with clinical solutions • Citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange, new digital channels** (e.g. online and video consultations) • Support for a **single transfer of care** approach, and **new models** of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care (NW London and pan-London CIEs) • **Integration of Co-ordinate My Care (CMC) for last phase of life plans** with acute, community and primary care systems; and promote its use in CCGs. through education and training and support care planning and management • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care **dashboards** across 350 GP practices will deliver direct, integrated patient care
4. Improving outcomes for children and adults with mental health needs	• Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Enable people to live full and healthy lives with the help of digital technology** • Innovation programme supported by the AHSN and industry leaders to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities – for example Patient Reported Outcome Measures (PROMs); **create online communities** of patients and carers; get children and young people involved through apps **Implement new models of care and 24/7 services where required** • Support for **new models** for out-of-hours and inter-disciplinary care, such as **24x7 crisis support services** and **shared crisis care plans** to deliver the objectives of the Crisis Care Concordat, through shared care records **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience
5. Ensuring we have safe, high quality, sustainable acute services	• Automate clinical workflows and records • Enable Patient Access • Build a shared care record	**Invest in digital technology in Hospitals** • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Support new models for out-of-hours care through **shared care records and the NWL diagnostic cloud**, such as 24x7 access to diagnostics, and pan-NW London radiology reporting and interventional radiology networks • Better digital tools to ensure **optimisation of acute resources**, e.g. radiology Clinical Decision Support, referral wizards and decision support tools, greater use of NHS e-Referrals including Advice & Guidance capability • Integrated **discharge planning and management**, and support for **acute-to-acute transfers**. through shared care records • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • **Dynamic analytics** to track consistency and outcomes of out-of-hours care • **Partnership model for informatics delivery** that makes best use of specialist technology skills across organisations

4. Primary Care

Primary Care in the context of out of hospital transformation

The challenges facing the NHS, and the need to radically transform the way we deliver care were set out in the Five Year Forward View (FYFV). In NW London, our STP sets out our ambitious plans to close the three gaps identified: health and wellbeing, care and quality and finance and efficiency. The development of a complete and comprehensive model of out of hospital care is critical to the delivery of these plans.

Our plans are for the development of integrated out of hospital care – Local Services – that will deliver personalised, localised, specialised and integrated care to the whole population. Patients will be enabled to take more control, supported by an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital admissions. This will improve health and wellbeing and care and quality for patients.

Our aim is to accelerate investment in infrastructure for a network of care hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of Primary Care services in NW London.

We will transform General Practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care is available to all, as set out in the Transforming Primary Care in London: a Strategic Commissioning Framework.

We will implement a substantial up scaling of intermediate care services, available to people locally, offering integrated health and social care teams outside an acute hospital setting.

Together, these parallel ambitions form our Local Services Transformation Programme, which brings together a range of high-impact initiatives (See boxes to right).

Enhanced Primary Care and related out of hospital service improvements are critical in achieving the ambitions set out in our STP. Our immediate and longer-term plans will deliver accessible and integrated care which offer 'right time, right care, right place'.

This document sets out our strategy for achieving these ambitions.

'There is arguably no more important job in modern Britain than that of the family doctor'

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated Primary Care is central to any country's health system. As a recent British Medical Journal headline put it – 'if General Practice fails, the whole NHS fails'. *General Practice Forward View – 2016.*

We are determined that NW London succeeds.

Enhanced Primary Care: Locally owned plans are in place for delivery of the SCF priorities – delivering extended access, patient-centred and pro-active care, and co-ordination across key parts of the system against a single shared care-plan

Self-Care: Embedding the self-care framework as a commissioning tool and implementing Patient Activation Measures (PAM) to support co-ordinated LTC management

Upgrading Rapid Response and Intermediate Care Services: delivering consistent outcomes and contributing to an integrated older peoples' pathway of care, in conjunction with **Last Phase of Life** and related initiatives

Transfer of Care: implementing a single, needs-based assessment process, with a single point of access in community services. This will ensure quick, co-ordinated discharge from acute services back in to the community, in partnership with Local Authorities

4. Primary Care
The local services landscape including primary care

Achieving an effective model of integrated out of hospital services is key to the delivery of the NW London STP. Within NW London, we have a highly diverse population, which is supported within Primary and Community Care by a mix of out of hospital services with varying levels of capacity.

We have achieved much since we began implementing Primary Care transformation across NW London in 2015, and Whole Systems Integrated Care in 2014, but we do not underestimate the remaining challenges. We now have Primary Care operating at-scale across NW London (diagram, bottom right). Our current plans for further transformation are underpinned by national and local policies and initiatives:

- **The 5 Year Forward View (5YFV)**

As part of our Local Services Transformation, we aim to tackle the triple gap identified in the 5YFV: Finance, Sustainability and Quality. All of our initiatives have had these priorities in the forefront of our planning, and are key components of NW London's STP.

- **The General Practice Forward View (GPFV)**

The GPFV sets out a plan, backed by a multi-billion pound investment, to stabilise and transform General Practice. The focus of the plan centres around workforce (incentivisation for recruitment and retention), workload (practice resilience) , infrastructure (estates and technology) and care redesign.

- **The Strategic Commissioning Framework (SCF)**

This is London's agreed approach to supporting the focus on Accessible, Proactive and Co-ordinated Care within Primary Care. Self-care is an integral part of proactive care contributing towards Enhanced Primary Care offer.

- **The GP Access Fund (GPAF)**

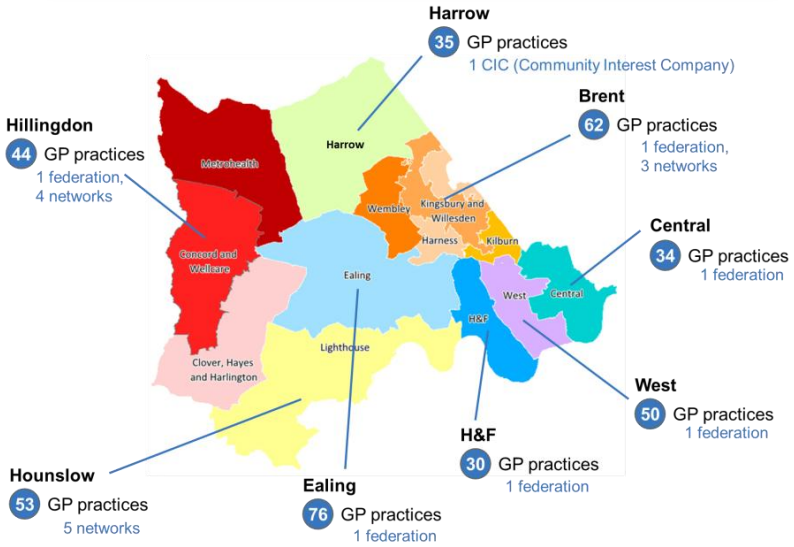
As part of the extended access aspects of Accessible Care, NW London will meet the extended access specifications by the end of Mach 2017, in order to better support our population to access Primary Care services more efficiently, at a time and place that suits them.

- **King's Fund and related reports**

Evidence based, national reports have indicated areas of focus for NW London. We have also utilised local knowledge from reviews and evaluation to assess our current status quo (blue box) and areas for development.

In NW London, we have:

- 1,093 GPs
- 473 practice nurses
- 273 clinical support staff
- Average list size 5,560
- GP and nurse workforce supply is the lowest in London
- 392 GP practices with 31 sites open at weekends
- 17 groups of GP providers
- 388 dental care practices
- 1,284 pharmacists
- Pharmacy and dental practice supply one of the best in London
- 5 different IC/RR services
- Multiple Single Points of Access (SPAs)
- Many care homes, often in disparate locations
- Differing provision of bedded and non-bedded care across NW London



4. Primary Care: CCGs have agreed to support Primary Care providers in delivering a clear set of standards over the next five years, in support of our vision

Proactive care	
Co-design	Work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve health and wellbeing
Developing assets and resources to improve health and wellbeing	Work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected and supported
Conversations focused on individual health goals	Where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
Health and wellbeing liaison and information	Enable and assist people to access (inc. in schools, community and workplaces) information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing.
Patients not accessing Primary Care services	Design ways to reach people who do not routinely access services and may be at higher risk of ill health.

Accessible care	
Patient choice	Patients have a choice of access (e.g. face-to-face, email, telephone, video)
Contacting the practice	Patients make one call, click, or contact to make an appointment. Primary care teams will actively promote online services to patients (inc. appointment booking, viewing records, prescription ordering and email consultations)
Routine opening hours	Patients can access pre-bookable appointments with a primary health professional at all practices 8am-6.30pm Monday to Friday and 8am-12 noon on Saturdays in a network
Extended opening hours	Patients can access a GP or other Primary Care health professional 7days a week, 12 hours per day (8am -8pm or alternative equivalent based on local need), for unscheduled and pre-bookable appointments
Same-day access	Patients can have a consultation (inc. virtually) with a GP or skilled nurse on the same day, in their local network
Urgent and emergency care	Patients can be clinically assessed rapidly. Practices will have systems and skilled staff to ensure patients are properly identified and responded to
Continuity of care	Patients are registered with a named team member, responsible for providing coordination and continuity, with practices offering flexible appointment lengths

Co-ordinated care	
Case finding and review	Practices identify patients, through data analytics, who would benefit from coordinated care and continuity with a named clinician, regularly and proactively reviewing those patients
Named professional	Patients identified as needing coordinated care have a named professional who oversees their care and ensures continuity
Care planning	Each individual identified for coordinated care is invited to participate in a holistic care planning process in order to develop a single shared electronic care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in care
Patients supported to manage their health and wellbeing	Primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing. including the use of digital tools and education, such as health coaching.
Multi-disciplinary working	Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving. Care will be coordinated via shared electronic care records.

4. Primary Care: A whole population approach to delivering integrated out of hospital care in NW London

We have developed a whole population approach to delivering integrated out of hospital care in NW London.

Majority of activity

Population segments

Service needs	Mostly healthy people	People with complex conditions
Planned	**Prevention measures as per defined protocols** • Lifestyle interventions, health education in schools, smoking cessation, screening • Choice of access options and **centralized scheduling** across multiple channels • Services are available at convenient times (e.g. **evenings and weekends**) • Prevention programs in collaboration with Local Authorities, e.g. walk-in classes	**Care by the same team in core hours** • Support with adhering to a care plan under the guidance of a **care-coordinator** • Tailored advice and support with self-management that includes social interventions and support • Preferred service and a **named clinician** are available for pre-planned appointments • Discharge coordination with hospital services • Infrastructure to support home-monitoring
Unplanned	**Easy access and information sharing** • Walk-in, telephone and tele-consultation options available, including out of hours • Support for self-care (e.g. online advice) • Advanced information sharing between services and professionals exclusively through **Electronic Health Records (EHR), also accessible to the patient**	**Rapid access, preferably to the core team** • **Single telephone line** to direct patients out of hours; otherwise **care coordinator** is main point of contact • Core team keeps sufficient **capacity for unplanned appointments** • All professionals **use EHR;** feed back most important events to the core team

Episodic Care[1]

- Main **emphasis on ease of access**
- Episodic care, overseen **by a qualified GP on duty** during normal and extended hours at a hub / dedicated practice or call centre
- **Patient-self management of limiting illnesses**

Continuous Care[1]

- Main **emphasis on continuity**
- Continuous care provided mainly during core hours by the **same team**, according to **a care plan**
- **Care coordinator** to serve as the first point of contact for the patient, and all other providers

1. Mostly healthy people can follow the "continuous" model of care situationally (e.g., when recovering from a complex surgery); people with complex condition can follow "episodic" model when treated for completely unrelated conditions (e.g. ankle sprain for a diabetic)

4. **Primary Care:** Primary care and Intermediate Care transformation is the foundation for Local Services Transformation

The transformation of Local Services is central to the delivery of the ambitions set out in the NW London STP.

Our challenges

- **Demand for health and care services is increasing.**
- **There is unwarranted variation in care, quality and outcomes across NW London.**
- **Our system is fragmented resulting in duplication and confusion.**
- **The cost of delivering health and care services is increasing.**

How Local Services areas of focus fit within STP delivery areas

DA2 — **Improve quality and reducing variation across Primary Care (for LTC management)**

DA3 — **Achieving better outcomes and experiences with a focus on older people**

What are the ways of working

- **Developing sustainable services**
- **Changing how we work together to deliver the transformation required**

Our areas of focus

- Promoting **self-care** and **prevention**
- Improved **access** and **co-ordination** of care
- Reducing pressure on A&E and secondary care
- Implementing **co-produced standards** for integrated out of hospital care
- Building on local work, knowledge of local work, curating **best practice**
- Improving access and linking the management of physical and mental health conditions to **reduce clinical variation** in LTC management

- Delivering **consistent outcomes** for patients within Primary Care, irrelevant of in which borough they reside
- Standardising the Older People's **clinical pathway**
- Standardising care across pathways, including **Intermediate Care Services and Rapid Response**
- Introducing contracting and whole population budgets
- Creating co-operative structures across the relevant of the system, e.g. older people cohort

- Joint commissioning and delivery models across CCGs and providers
- Evolving **Primary Care at-scale**
- Managing demand across boundaries through pathway redesign
- **Strengthening care teams** to provide effective care

- Effective **joint governance** able to address difficult issues
- Working **cross-boundary**; across acute and social care
- Collaborating to improve quality and efficiency, e.g., through the Virtual Primary Care Team
- Building upon **Whole Systems Integrated Care**

The impact of our plans

A healthier NW London

- Early identification and intervention, leading to better health outcomes for the population
- Reduction in A&E attendance, non-elective admissions, length of stay, and re-admissions
- Delivery of care in more appropriate settings
- Cross-organisation productivity savings from joint working
- Consolidation and improved efficiency, in commissioning and delivery of care
- Improved patient satisfaction from better access, quality of care and integrated care.

More productive care:

- Increased collaboration
- Reduced duplication
- Management of flow
- Sustainable Primary Care providers and provision of care

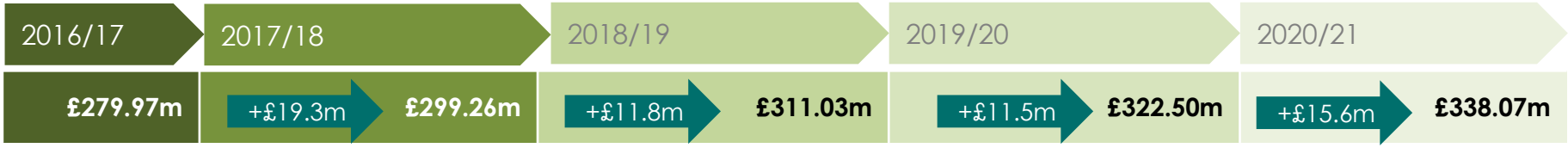
More effective system:

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

4. Primary Care: There will be significant investment in General Practice within NW London

This diagram shows NW London's:

- Efficiency targets
- Increases in primary care medical allocations (blue arrows)
- The planned delivery of the Strategic Commissioning Framework and the Strategy and Transformation Plan

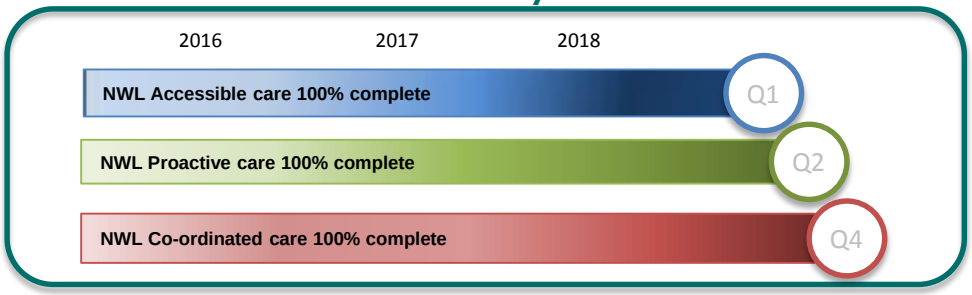


Key — Increases in Primary Care medical allocations

The diagram does not show funding from national programmes (such as the General Practice Access Fund) from which NW London is aiming to access approximately £4.5m in 2016/17 – announced in the GP Forward View.

Primary care services in NW London deliver high-quality care for local people. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. Transforming general practice in line with the standards set out in the Strategic Commissioning Framework is critical to delivery of the ambitions set out in the STP. The diagram below shows the milestones to full delivery.

Milestones for SCF delivery across NW London



5. Finance:
Overall Financial Challenge – 'Do Something' (1)

The STP has identified 5 delivery areas that will both deliver the vision of a more proactive model of care and reduce the costs of meeting the needs of the population to enable the system to be financially as well as clinically sustainable. The table below summarises the impact on the sector financial position of combining the normal 'business as usual' savings that all organisations would expect to deliver over the next 5 years if the status quo were to continue, with the savings opportunities that will be realised through the delivery of the 5 STP delivery areas, and demonstrates that overall the footprint including social care has a small deficit of £19.9m.

£'m	CCGs	Acute	Non-Acute	Specialised Commissioning	Primary Care	STF Investment	Sub-total	Social Care	Total	
Do nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	-	**(1,112.4)**	**(297.5)**	**(1,409.9)**	**Note 1**
BAU Savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	108.5	**680.6**	**Note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	**(4.0)**	-	**(4.0)**	
Delivery Area 1 - Savings	15.6	-	-	-	-	-	**15.6**	8.0	**23.6**	
Delivery Area 2 - Investment	(5.4)	-	-	-	-	-	**(5.4)**	-	**(5.4)**	
Delivery Area 2 - Savings	18.5	-	-	-	-	-	**18.5**	-	**18.5**	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	**(52.3)**	-	**(52.3)**	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	**134.9**	33.1	**168.0**	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	**(11.0)**	-	**(11.0)**	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	**22.8**	6.4	**29.2**	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	**(45.6)**	-	**(45.6)**	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	**254.5**	15.0	**269.5**	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**	**Note 4**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**	**Note 4**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**	
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	-	**1,127.5**	262.5	**1,390.0**	
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	-	-	-	**15.1**	**(35.0)**	**(19.9)**	
				Note 5				**Note 3**		

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since Jun '16 STP due to changes in the underlying position of social care, and inclusion of the Royal Brompton & Harefield and the London Ambulance Service deficit attributable to NWL.

Note 2: BAU CIP and QIPP is those that can be carried out by each organisation without collaboration, etc.

Note 3: See Social Care Finances gap closure slide (aligned to Delivery areas where applicable).

Note 4: £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated.

Note 5: Specialised commissioning have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed. This is a placeholder.

Note 6: As we have developed our project plans we have more clearly articulated the focus of our delivery areas. This has resulted in 'Delivering the SCF' moving from DA3 to DA2. The individual DA totals have therefore changed although overall investment and saving totals remain constant.

5. Finance:
Overall Financial Challenge – 'Do Something' (2)

The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a break even position .

BAU CIPs and QIPP The CIPs and QIPP that could be delivered by providers and commissioners in 16/17 – 20/21 (total £570m), including Carter, but without transformation (i.e. Status Quo)

Delivery Areas (1-5) - CCGs – The financial impact of the 5 delivery areas has been calculated and broken down between CCGs and providers. For CCGs they require £118m of investment to deliver £303m of savings.

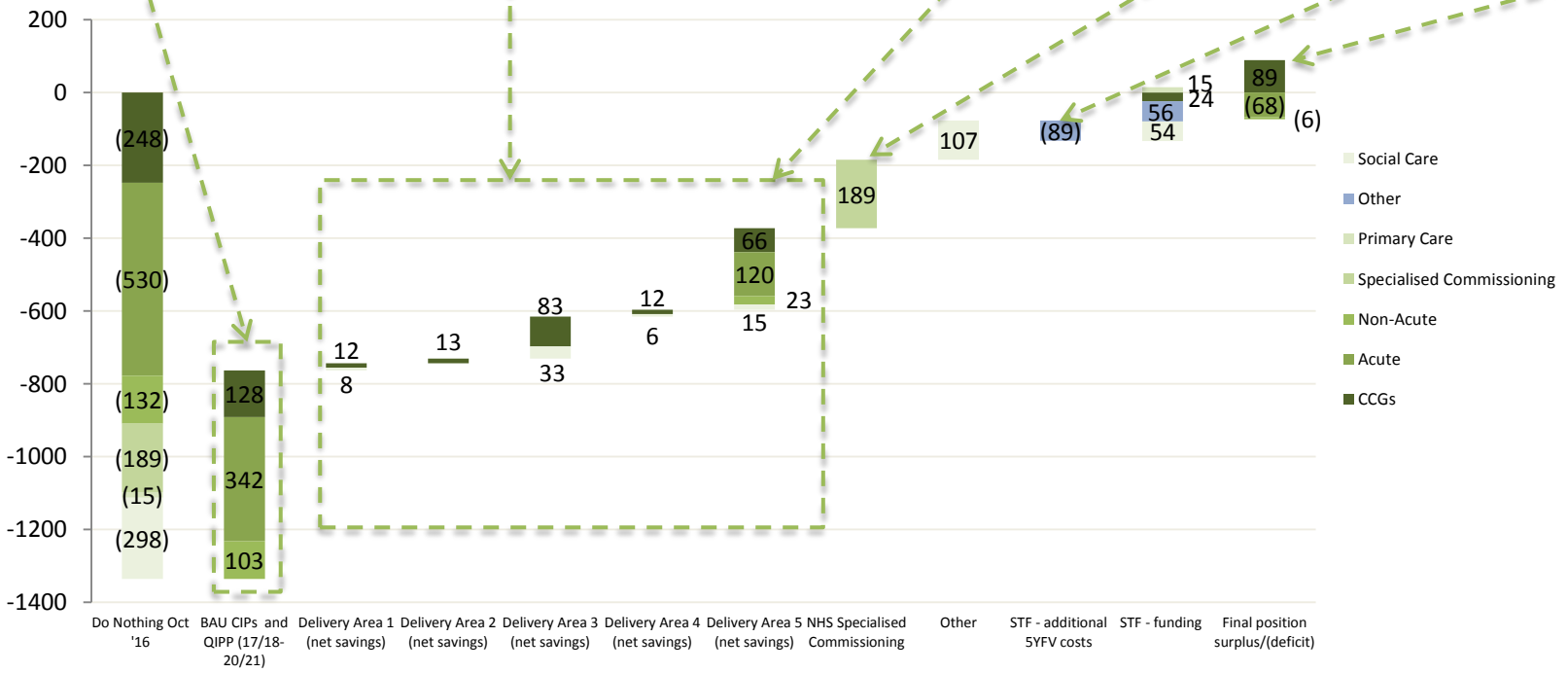
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

Delivery Areas (1-5) - Providers Quantum opportunity for trusts, delivered through cross sector collaboration, service change and other local opportunities

NHSE spec Comm NHSE spec comm have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed

STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

Final position CCG Surplus (£89m) Acute deficit (£68m) Non-acute deficit (£6m)



5. Finance:
Next steps

Financial risks to delivery of the STP

There are a number of risks facing NWL commissioners and providers which are inherent in the STP. These are:

- Delivery of business as usual efficiency savings
- Delivery of the service transformations set out in the five delivery areas, and the realisation of the associated savings
- Financial challenges on the provider side that remain at the end of the STP period
- Plans to close the specialist commissioning gap are not yet available
- Deterioration in underlying organisational financial positions since 2016/17 plans were agreed
- Closing the remaining social care funding gap
- Accelerating delivery of transformation plans to enable recently notified NHS financial control totals to be achieved.

The key risk to achieving sector balance is the delivery of the savings, both business as usual efficiency savings and those associated with the service transformations described in the five delivery areas.

There are also particular challenges in relation to:
- The deficit on the Ealing Hospital site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging;
- The deficit at the Royal Brompton and Harefield, which although mostly commissioned by NHSE Specialised Commissioning, is included in the NWL footprint;
- The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution.

The plans to close the Specialised Commissioning gap are not yet available in enough detail to allow an assessment of the level of risk facing the NWL Specialised service providers. This may pose a significant risk to the viability of some providers.

Next steps to address the risks

There are a number of processes in place to quantify and mitigate the risks set out above. These include:

- A robust process of business case development to validate the investments and savings that have been identified so far, and the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered
- A portfolio management approach with clear governance to ensure that project directors are held accountable for delivering agreed savings, with a change control process to close projects and agree new ones as required to deliver the planned patient outcomes and associated savings
- The work through DA5d on productivity will support the development of trust internal infrastructures to support the business as usual efficiency savings
- The acceleration of the changes relating to Ealing hospital, once out of hospital capacity is in place
- Joint pathway planning with specialist commissioning and other CCGs across London to confirm the plans to reduce demand and to quantify the impact on providers
- Quantification of changes in underlying financial positions and differences between the STP financial assumptions and notified control totals, feeding into a sector approach to the 2 year contracting round to ensure that effective risk management processes are in place.

This work will be developed and will continue over the next few months.

5. Finance:
STP financial enablers – Sustainability and Transformation Funding

To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. The STF funding being use to support provider deficits has already been notified to Trusts for 17/18 and 18/19, and is not included below. The funding below is being sought **in addition** to provider STF funding.

Sustainability and Transformation funding requirement for North West London

Investment Area	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Investment in Prevention & Social Care	21.0	25.0	30.0	34.0
Social Care funding gap	-	-	-	19.5
Total Social Care and prevention	**21.0**	**25.0**	**30.0**	**53.5**
Seven Day services roll out through to 2019/20	4.0	7.0	12.0	24.0
General Practice Forward View and Extended GP Access	10.0	10.0	5.0	5.0
Increasing capacity in Child and Adolescent mental health services and reducing waiting times in Eating Disorders services	5.0	5.0	8.0	10.0
Implementing recommendations of mental health task force	10.0	10.0	10.0	5.0
Cancer taskforce Strategy	3.0	5.0	10.0	3.0
National Maternity Review	7.0	7.0	2.0	2.0
Local Digital Roadmaps supporting paper free at the point of care and electronic health records	3.0	10.0	10.0	6.7
Total Health	**42.0**	**54.0**	**57.0**	**55.7**
Improvement Resources	2.0	2.0	-	-
Additional Investment in Primary Care services	1.0	12.0	19.0	14.8
System support funding	-	-	-	24.0
Total	**66.0**	**93.0**	**106.0**	**148.0**

5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £978m (funded by £713m from internal resources, £37m from disposals and £228m from external funding.) The table below shows the total capital requirements over and above the 'Do Nothing' Capital under the 'Do Something' scenario, over the five years of the STP planning period. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

The table below details the 'Do something' capital for the 5 year STP period.

Table : Do Something Capital

Key Capital Schemes	17/18-20/21 £m	Less: disposals £m	Other funding sources £m	Total £m
	Gross Capital			Net capital
Outer NWL (SOC1)[1]	385	(9)		375
Inner NWL (SOC2)[2]	222	(222)		-
IT Digital Roadmap[3]	60			60
CNWL - strategic investments	79	(53)	(26)	-
Royal Brompton	100	(100)		-
Total	**845**	**(384)**	**(26)**	**435**

Note 1 – The Outer NWL business case (SOC1) is modelled on an 'accelerated' approval timeline in order to address the sustainability issue at Ealing Hospital;
Note 2 – The Inner NWL Business Case (SOC2) is funded through the disposal of a charitable asset, thus placing a restriction on the use of the sale proceeds;
Note 3 - IT digital roadmap funding is expected to be funded via the Estates and Technology Transformation Fund (ETTF).

6. Risks and Mitigations:
Strategic Risks

We have described an ambitious plan to move from a reactive, ill health service to a proactive, wellness service, that needs to be delivered at scale and pace if we are to ensure we have a clinically and financially sustainable system by 2020/21. Unsurprisingly there are many risks to the achievement of this ambition, which we have described below. In some areas we will need support from NHSE to enable us to manage them.

Risks	Category	Proposed mitigations	Support from NHSE
We are unable to shift enough care out of hospital, or the new care models identify unmet need, meaning that demand for acute services does not fall as planned	Quality and sustainability	• Maintain system attention on importance of delivery over the next five years through focus on Delivery Areas 1, 2 and 3 • Continue to develop delivery plans using learning from vanguards and other areas • Establishment of robust governance process across NW London system focussing on both delivery and assurance • Clear metrics agreed to monitor progress	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	• Support development of GP federations • Early investment in primary care through joint commissioning • Identification and support to vulnerable practices • Digital solutions to reduce primary care workloads	• Support in developing a reliable understanding of sector demand and capacity for primary care
Can't get people to own the responsibility for their own health	Self care and empowerment	• Development of a 'People's Charter' • Closer working with local government to engage residents in the conversation, primarily through DA1	• National role in leading conversation with the wider public about future health models
We are unable to access the capital needed to support the new care model and to address the existing capacity and estate quality constraints, and the sustainability issues at Ealing Hospital	Finance and estates	• Submit a business case for capital to NHS England • Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment • Identification of further opportunities through One Public Estate • Submit a business case for capital to NHS England that sets out the clinical and financial rationale for an accelerated timeline	• Support for retention of land receipts for reinvestment, and potential devolution asks • Support for an accelerated timeline for the capital business cases
Information Technology systems are not in place to enable seamless integrated care and a shift towards out of hospital activity.	Information and technology	• Work within new national standards on data sharing to support the delivery of integrated services and systems. • Keep pressure on primary and community IT system providers to deliver open interfaces which will enable record sharing	• NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability. • Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality • Continued focus at a national level on open API

6. Risks and Mitigations:
Other Risks

Risks	Category	Proposed mitigations	Support from NHSE
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	• On-going quality surveillance to reduce risk • Contingency plans developed should a service be flagged as *fragile* • Strengthened governance structure with clear joint leadership maintaining focus on delivery and enabling more rapid and effective responses to a situation	
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	• Development of a joint market management strategy lead by the Joint Health and Care Transformation Group • Specific project of work in this area through DA3 • On-going support to homes to address quality issues	
Provider and system sustainability targets result in competing local priorities	Quality and sustainability	• Joint Health and Care Transformation Group provides forum for system wide discussion.	• Alignment of NHS England and NHS Improvement positions on provider sustainability versus system sustainability
We are unable to recruit or retain workforce to support the old model while training and transforming to the new model of care	People and workforce	• Establishment of Workforce Transformation Delivery Board to provide system leadership and focus • Development of cross-sector workforce strategy • Close working with HEENWL	
There is resistance to change from existing staff	People and workforce	• OD support and training for front line staff and system leaders • Wide staff engagement in the design and delivery of new models through project delivery groups.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	• Work closely with partners to understand the implications of 'Brexit' • Provide staff with support to ensure they feel valued and secure.	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	• Developing relationships between health and local authority organisations, supported by joint governance via the Joint Health and Care Transformation Group • Joint statement agreed and areas of commonality identified to enable progress	

7. References

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
Case for Change	12-19	[1] Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea. [2] NOMIS profiles, data from Office for National Statistics [3] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [4] Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs

7. References

Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) Management	23-26	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] Cancer Research UK [3] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf [4] Fund Naylor C, Parsonage M, McDaid D et al (2012). Long-term conditions and mental health: the cost of co-morbidities. London: The Kings Fund [5] Pan-London Atrial Fibrillation Programme [6] NHS London Health Programmes, NHS Commission Board, JSNA Ealing [7] Kings Fund, 2010 [8] Initial analysis following review of self-care literature [9] http://dvr.sagepub.com/content/13/4/268

7. References

Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	27-28	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
Delivery Area 4: Improving outcomes for children and adults with mental health needs	29-30	[1] Tulloch et al., 2008 [2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf [4] Royal College of Psychiatrists, 2012 [5] http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060124/debtext/60124-06.htm#60124-06_spmin1
Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	31-33	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
Enablers: Estates	35-38	[1] ERIC Returns 2015/16 published 11 October 2016 [2] NHSE London Estate Database Version 5 [3] NW London CCGs condition surveys [4] Oxford University's School of Primary Care Research of general practices across England, published in The Lancet in April 2016 [5] Lord Carter Report: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/http://qna.files.parliament.uk/ws-attachments/450921/original/Operational%20productivity%20and%20performance%20in%20English%20NHS%20acute%20hospitals%20-%20Unwarranted%20variations.pdf

7. References

Section	Slides	References
Enablers: Workforce	39-41	[1] Trust workforce: HEE NWL, eWorkforce data, 2015. Not published Social Care Workforce: Skills for Care, MDS-SC, 2015 GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published [2] Conlon & Mansfield, 2015 [3] Turnover Rates: HSCIC, iView, retrieved 23-05-2016 [4] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015 [5] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016 [6] GP Appointments: Nuffield Trust, Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice, 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016 [7] McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published
Enablers: Digital	42-43	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

NW London Sustainability and Transformation Plan

Appendices

Our plan for North West Londoners to be well and live well

V1.0

21 October 2016

List of appendices

	APPENDIX TITLE	PAGE
Appendix A	Joint Statement on Health and Care Collaboration in North West London from the boroughs of Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster	3
Appendix B	How our STP addresses the nine national priorities	5
Appendix C	Further information about our Mental Health and Wellbeing Transformation	10
Appendix D	Communications and Engagement	16
Appendix E	You said, we did – Response to patient and organisation feedback on the 30 June Submission	29

Appendix A: NWL Sustainability and Transformation Plan

Joint Statement on Health and Care Collaboration in North West London from the boroughs of Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster

Appendix A: Joint Statement on Health and Care Collaboration in North West London from the boroughs of Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster

The six boroughs welcome the opportunity to improve the outcomes for local people and communities

- Local Government and Health partners in North West London (NWL) are committed to working together to design a sustainable health and care system that improves outcomes for our communities
- We recognise the huge financial and demographic challenges facing public services over the next five years and acknowledge our duty to work together as system leaders to create a sustainable health and care system, whilst retaining our rights as sovereign organisations to help our communities get the outcomes they need
- We support person-centred health and care that enables increased numbers of older people and those with disabilities to access clinical and social care in community settings whenever appropriate
- We welcome joint working with the NHS to prevent health problems occurring and to improve the wellbeing of local people. We are committed to working together to deliver integrated health and social care systems that provide the highest quality out-of-hospital services for residents
- The councils will work closely with NHS partners to implement work in these areas, building on our strong track record of partnership delivery.

In order to deliver the ambitions of the STP, the six boroughs also agree that the following conditions must be reflected in the STP:

1. Explicit reference to how the NHS will help to close the social care funding gap, through investment in prevention and integration services
2. Explicit reference to the need to map and invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government
3. Explicit reference to plans to significantly expand pooled budgets and joint commissioning for delivery of integrated and out of hospital care, especially for older peoples services, to support the development of the local and NW London market
4. Explicit reference to a devolution proposition around local retention of capital receipts from estates and joint commissioning of all out of hospital care, with resources allocated to deliver it. This in no way infers any assumptions about acute reconfiguration
5. There will be no substantive changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met
6. A commitment from NHS partners to review with local authority partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes
7. A commitment to work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety and quality concerns and expected demand pressures.

Any changes to this agreement will be subject to joint review based on agreed criteria with local authority partners and communities.

Concerns still remain around the government's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in North West London or downgrade the status of Ealing or Charing Cross hospitals, including A&E services.

We recognise that there is significant work still to do to develop a genuinely joint approach and reach agreement on any hospital changes in these areas. At the same time, the boroughs recognise the significant opportunity to work together to invest in better care for local residents.

The boroughs ask that NHS partners commit to work jointly to:

- Continue to develop an agreed approach to the delivery of the commitments
- Develop an acceptable set of review criteria for any changes
- Strengthen the supporting data and evidence base, and understand the Financial risks and benefits and overall business case across health and care
- Agree a 'review point' in 2018 to review the agreed criteria
- Continue to co-produce the final delivery plan with leaders, clinicians and the public.

Appendix B: NWL Sustainability and Transformation Plan

How our STP addresses the nine national priorities

Appendix B: How our STP addresses the nine national priorities

National Priority Area	National Description of Delivery Requirements	Section of NW London STP
1. STPs	• Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.	• Addressed through finance template, STP and delivery plans.
2. Finance	• Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing Right Care; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving roistering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.	• Section 5 for financial summary. • Delivery Areas 1-5 for demand management initiatives. • DA5d for collaborative provider productivity improvements.
3. Primary Care	• Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes. • Ensure local investment meets or exceeds minimum required levels. • Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.	• DA2a for Delivering the Strategic Commissioning Framework and General Practice Forward View. • Workforce enabler for approach to primary care workforce planning. • Primary care plan in the out of hospital chapter for further detail on access and general practice at scale.

Appendix B: How our STP addresses the nine national priorities

National Priority Area	National Description of Delivery Requirements	Section of NW London STP
4. Urgent & Emergency Care	• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.	• DA2e for self care, DA3c for intermediate care, DA4a for mental health model of care and DA4c for crisis support, all resulting in lower U&EC usage. • DA2a for 24/7 integrated care service. • DA5b for seven day hospital services.
5. Referral to Treatment Times and Elective Care	• Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, *Better Births*, through local maternity systems.	• DA5c for out of hospital hub development and maternity service improvements. • DA5d for improved elective care productivity. • Digital enabler for e-referrals. • DA5c for continuing improvement to maternity services.

Appendix B: How our STP addresses the nine national priorities

National Priority Area	National Description of Delivery Requirements	Section of NW London STP
6. Cancer	• Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report. • Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards. • Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. • Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types. • Ensure all elements of the Recovery Package are commissioned, including ensuring that: i) all patients have a holistic needs assessment and care plan at the point of diagnosis; ii) a treatment summary is sent to the patient's GP at the end of treatment; and iii) a cancer care review is completed by the GP within six months of a cancer diagnosis.	• DA2c for improvements to cancer services.
7. Mental Health	• Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including: - Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care; - More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018; - Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral; - Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline; - Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and - Reduce suicide rates by 10% against the 2016/17 baseline. • Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. • Increase baseline spend on mental health to deliver the Mental Health Investment Standard. • Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. • Eliminate out of area placements for non-specialist acute care by 2020/21.	• DA4a for implementation of the MHFYFV. • DA1c and DA4d for focus on children's mental health and wellbeing. • DA4c for crisis support services. • DA2a for integrated approach to dementia support.

Appendix B: How our STP addresses the nine national priorities

National Priority Area	National Description of Delivery Requirements	Section of NW London STP
8. People with Learning Disabilities	• Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. • Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population. • Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check. • Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.	• DA4b for delivery of the NWL Transforming Care plan. • DA2d for Right Care as an enabler to support Transforming Care. • DA1b for access to healthcare and annual health checks. • Digital enabler for innovative support tools.
9. Improving Quality in Organisations	• All organisations should implement plans to improve quality of care, particularly for organisations in special measures. • Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services. • Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.	• DA5b for focus on service quality improvement. • DA5d for acute care productivity and quality improvement. • DA4a for focus on mental health services. • Workforce enabler for workforce planning and strategy.

Appendix C: NWL Sustainability and Transformation Plan
Further information about our Mental Health and Wellbeing Transformation

The current picture

In North West London we have had a shared whole systems mental health programme (across health and social care) since 2012 reflecting a commitment to improving mental health and wellbeing for the 2 million residents of North West London. Since 2015 we have been working under the banner of Like Minded – with a Case for Change endorsed across all Health and Wellbeing Boards, and CCGs setting out our challenges and common ambition for change.

The programme coproduced the following 3 statements to articulate the overall vision our population. These statements are supported by a number of principles. Critically the Strategy, vision and principles describe the outcomes and experience we want to change – rather than focus on services.

My wellbeing and happiness is valued and I am supported to stay well and thrive

As soon as I am struggling, appropriate and timely help is available

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

Core principles

- My life is important, I am part of my community and I have opportunity, choice and control
- My wellbeing and mental health is valued equally to my physical health
- I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing
- My care is seamless across different services, and in the most appropriate setting
- I feel valued and supported to stay well for the whole of my life

The Like Minded Strategy is a 'whole systems', all ages strategy. Throughout the programme we recognise the critical role that services and initiatives across the system have in supporting mental health and wellbeing. Our combined work across NWL naturally builds on the local transformation and co-production work within each Borough, and on work led by local mental health providers – CNWL and WLMHT. As a transformation programme with a wide remit we embed in NWL the sense that mental health is everyone's business – through supporting our own workforce to remain healthy, as much as focusing on supporting the mental wellbeing and recovery of our service users, carers and wider population.

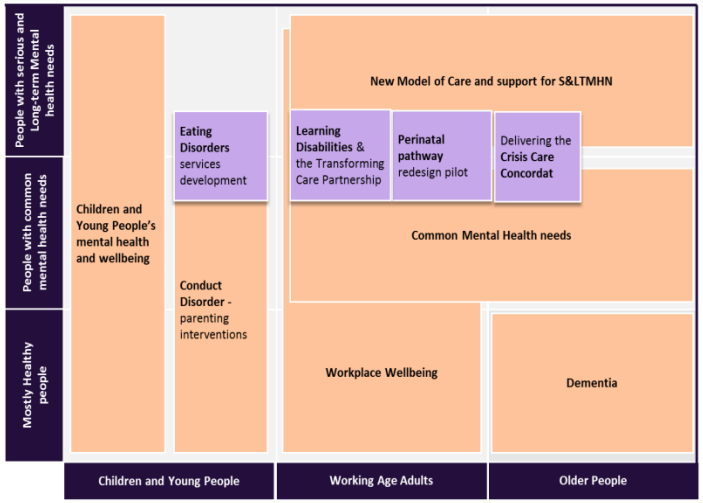
As we have approached mental health transformation in North West London one key commitment has been to **co-production –** not just with service users and carers, but through a cross-system leadership approach in health, social care and the voluntary and community sector. Our work to date lends itself to a 'place based approach' - with no health without mental health we have to work with a wide range of partners and recognise the impact of mental illness on all statutory services and broader societal outcomes, such as employment and educational attainment.

the whole programme is focused on delivering the ambitions for **Parity of Esteem**, all transformation work rooted in a holistic approach to meeting the needs of the public.

We work closely with service users and carers, clinicians, professionals and experts across the system in health, social care, voluntary sector and public health and have held workshop events in specific areas, including children & young people, socially excluded groups, and mental ill health prevention.

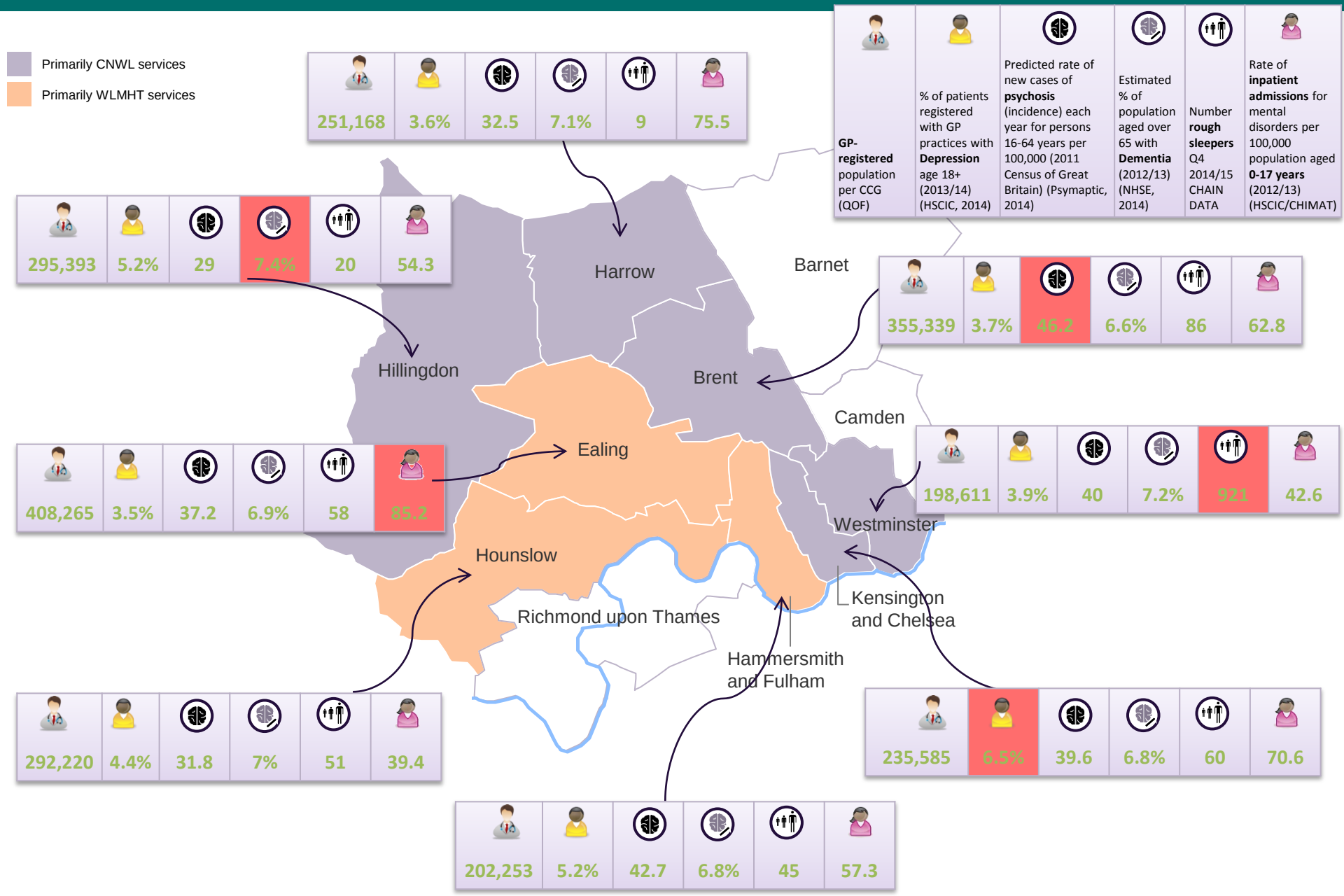
We are not starting from scratch – our 24/7 urgent care pathway has been the critical development over the last year and unlocks the gateway to wider services for adults with serious and long term needs. We have also developed primary care mental health services, specialist pathways for children and perinatal services as examples of work to date. But everyone working together on mental health transformation would recognise there is still much more we can do to improve the experience of our population – and the national focus, strategy and leadership provides additional focus and clarity on our priorities.

The 24/7 crisis line is the best anti-anxiety drug for GPs –we know we can get the right specialist support quickly for patients in the community



In approaching mental health transformation in North West London we have considered an approach across the life course aimed at reducing mental health inequalities. Whilst we know that people are not defined by their diagnosis (we acknowledge that comorbidity is the norm) or demographics, this is a useful framework to prioritise and focus within an area of vast need. We recognise that learning disabilities and mental health needs are not the same thing – but our work since 14/15 to address needs of our population who have both learning disabilities and mental health needs provided a spring board for wider work on learning disabilities under the Transforming Care Partnership Programme.

There is still much we can do to improve outcomes and reduce variation



Within the transformation programme our work on a new whole systems pathway has the greatest impact on the greatest number of people

The model below has been coproduced with partners across the system – and is the core of our activity and financial modelling which in turn supports achievement of the change set out in the mental health Five Year Forward. This work is focused on improving services for the 37,500 adults in North West London with serious and long term mental health needs.

Principles

- Care and support should be safely provided in the least intensive setting necessary
- As risk of relapse increases, additional support should be rapidly available
- Individuals will have needs that simultaneously exist across the system
- People can seamlessly transition between boxes not just those adjacent (i.e., not a tiered system)

Increasing intensity of need

Whole Systems model focused on the community

Urgent care pathway

Living a Full and Healthy Life in the community	Coordinated Community, Primary and Social Care	Specialist Community based support	Urgent/ crisis care to support stabilisation	Acute inpatient admissions
Support to people and carers to effectively manage their own mental health and wellbeing at home and in their community with a focus on prevention	Continuity of care and support around individual needs including co-produced care-plan, case management, and proactive multi-disciplinary support	Specialist care for individuals with higher intensity needs that require ongoing support for complex needs or specialist care packages (e.g., psychosis, PD)	Support to anyone feeling in crisis including 24/7, single point of access, timely assessment, more crisis management and recovery at home and in the community	Inpatient admission when community-based support is no longer appropriate, and for shortest time necessary with continuity in the community to support recovery to living well

Better transitions and transfers across different parts of the system

Enablers to support integrated working including shared data and new governance and payment models

Living well in least intensive setting

As a transformation programme with a wide remit we embed in NWL the sense that mental health is everyone's business

With the publication of the Mental Health Five Year Forward and supporting Implementation plan in 2016 across North West London we have mapped our existing plans (as set out in the Like Minded Case for Change and defined in the June submission of the STP) against the national must-dos.

The table below describes the congruence that exists and where there are additional areas that we need to place more focus on. We also describe where existing workplans exist – with clear financial modelling, defined outcomes and shared milestones. There remain some areas where more detailed work is ongoing to support delivery from 17/18 and beyond. We note a range of additional guidance is expected over the next 18 months and also opportunities to secure additional funding above that which will be made available through the CCG baseline allocations.

Lastly we are committed to work with colleagues across London – supported by Healthy London Partnerships – to take advantage of areas where we can avoid duplication and simplify pathways across the Capital.

The Mental health Five Year Forward – mental health workstreams are threaded throughout the STP to ensure integration with other key work programmes.

Detailed Plans developed	NWL STP	Outline plans developed (to be agreed by end Q3 16/17	NWL STP	Further work required	NWL STP
Children and Young People's Mental Health - Eating Disorder services lives - Crisis Care pathway pilot live - New Model of Care in development	DA4d	**Adult Common Mental Health Needs** - Workstream formed and Hillingdon agreed as NHSE pilot area - Good work on digital support, employment and GP engagement - Detailed implementation plans for increase in IAPT provision for LTC	DA2b	**Adults, community acute and crisis care** - Co-commissioning Mental health care for armed forces community to be developed	DA4b
Perinatal Mental health - Service live in 4/8 boroughs - Coproduction underway to commence in 4/8 boroughs in 17/18	DA4b	**Health and justice** - Good joint work on Childrens pathways/youth offending - Liaison and Diversion a priority for Crisis Care group in 17/18	DA4d DA4c	**Adults mental health, secure pathway** - Specialised commissioning now have a place on the Delivery Area 4 Board. Plans required for future years	DA4b
Adults, community, acute and crisis care - Detailed plans coproduced in most areas - Early Intervention in psychosis - Healthchecks - Independent Placement Support (employment) - Liaison Psychiatry Services Core 24 - Increased access to HTT – developed in 15/16 with a 24/7 service	 DA4c DA4a DA1b DA4c DA4a	**Suicide prevention** - Good borough based plans and activity to date - Any joint work to be agreed in collaboration with GLA and work on the Mental Health roadmap for London	DA4		
Sustaining Transformation - New Model of Care for CAMHS pilot across NWL - Governance and resource exists to support transformation	DA4d DA4	There are also a number of workstreams within the NWL programme which are not explicitly referenced in the Mental Health Five Year Forward - Delivery the Transforming Care Partnership (DA4b) - Social Isolation and loneliness (DA1b) - Prevention of Conduct Disorder (DA1c)			
A healthy NHS workforce - NHS organisations across NWL signed up to the Healthy London workforce charter	DA1b				
Infrastructure and hard-wiring - Workforce – a sub-group focusing on mental health exists - Payment and Outcomes					

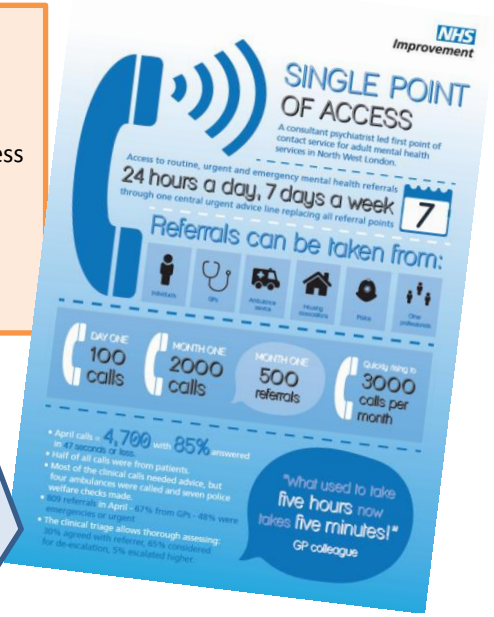
Our financial modelling reflects
- Parity of esteem
- Detailed business case modelling where completed
- The NWL share of new funding for mental health – and expected savings

The SPA – Implementation and Early Impact

Across North West London the 8 Clinical Commissioning Groups, West London Mental Health Trust (WLMHT) and Central & North West London NHS Foundation Trust (CNWL) have a longstanding commitment to improving the experience and outcomes of their population with mental illness.

Through a process of co-production, we have implemented a single point of access (SPA) 24/7/365 telephone line, with access to rapid response and home treatment covering the entire North West London population of 2.2 million people who may need support in a mental health crisis.

The SPA is a 24 hours a day, 7 days a week central advice line, accepting referrals from individuals, GPs, the ambulance service, housing associations, the police, and anybody else with access to a phone.



"The service allows me to give all the information quickly with one phone call. When you're a busy GP and your patient's in distress you want to help them as soon as possible. Being able to get advice and answers quickly with one phone call makes a huge difference"

On average, WLMHT received 3,439 calls per month between April and June

- Through our available measurable statistics, we believe the benefits within the mental health system are already apparent.
- The quick, paperless access to a clinical opinion has significantly cut the amount of time between a crisis being reported, evaluated and acted upon
- Previously there were around 15 different ways to refer into services and no clear way to track waiting times, frustrating for all involved. Now, having a clear single point of access means a quicker and more sensitive response.
- Across the collaboration demand is clearly rising but we are confident that the triage process and de-escalation trend we are seeing are supporting GPs help their patients in the community. The clinical triage allows thorough assessing: 30% agreed with referrer, 65% considered. For de-escalation, 5% escalated higher.
- Both CNWL and WLMHT (providers of the service) produce detailed dashboards describing activity, and ahead of formal evaluation this supports a clear picture of the way in which the services are meeting an obvious need for our population. The approach is now embedded in local pathways and referenced as a clear example of 7 day services. We are currently evaluating the services across NWL.
- GPs have reported that the 24/7 line has led to increased confidence in dealing with mental health crises. Overall feedback from GPs has been very positive: One GP fed back that "the Single Point of Access is the best anti-anxiety drug for GPs"

A Case Study:

A Senior Practitioner, C, in the SPA received a crisis call. An emergency intervention was requested for a female, S. Her son had recently been diagnosed with ADHD and had been allocated a social worker who was working with both of them. When the social worker got to the house, she found S in a very anxious state, clearly experiencing some kind of break down. Our senior practitioner spoke to both the Social Worker and then to S. S was previously known to services and had counselling in primary care years ago when depressed following a relationship break-up. After years of not being able to cope with her son, he has "finally got a diagnosis", and she is "finally getting support for him and for herself". Along with the relief of finally getting help, all the old anxiety and low mood to come to the surface. The Senior Practitioner managed to talk her down and to explore what she needed. She clearly didn't need or want secondary mental health services, but identified that talking therapies had helped in the past and this is what she now wanted again.

C referred her on to (IAPT) Talking Therapy service – S was really happy with the outcome and grateful for her help. This rapid response de-escalated the crisis, supporting the family to ensure they were happy.

Appendix D: NWL Sustainability and Transformation Plan

Communications and Engagement

Communications & Engagement (1): Guiding principles and initial engagement with our patients, residents and staff

We continue to ensure that people's voices drive our decision-making:

In NW London we collaborate with residents, patients and staff at all stages of the commissioning, mobilisation and delivery cycle; **co-production with service users is fundamental to our culture** and we have been recognised for our 130 strong Lay Partner Forum and its approach to co-production, which includes significant engagement with other patient groups including Healthwatch and Patient and Public Participation Groups.

We have joint governance and leadership across the communications and engagement space, with a work stream led by the CCG Director of Communications in partnership with communications leads from providers and local government. This group sets the overall direction for communications and engagement but working in partnership with colleagues from across all sectors involved in the STP.

We follow best practice in all the work we do, with all our engagement guided by the principles that we discuss early and that we listen. We will work in partnership with commissioners, providers, local government, Healthwatch, patients groups and residents associations.

Building on our history of collaborative working the STP is already a product of the work we have done with the wider community. The engagement so far has been to help us co-design the local plans and formulate the emerging priorities and delivery areas.

Having established the delivery areas in the checkpoint submission the purpose of this phase is to engage our partners, staff, patients and residents on whether our focus is right and what more they would like to see.

Engagement – Work done to support the development of the plan (April – July)

At a local level we:

- Held 22 face to face engagement events across all eight boroughs to help co-design the local plans, on top of regular meetings of the STP planning groups
- These events have included workshops, seminars and public meetings and been very popular with providers, patients, Healthwatch, carers and their families and lay partners
- We have also used Health and Wellbeing Boards along with CCG Governing Body meetings to engage people
- In Brent the Healthy Partners Forum had a turnout of around 100 people with table discussion focussed on the emerging priorities, while in Hillingdon over 100 people attended a STP focussed workshop
- We have promoted these events through our social media platforms to maximise attendance
- These local plans, co-designed with the local community, in turn form the basis for the full North West London STP.

At a pan North West London level we have:

- Hosted two co-production workshops with lay partners, Healthwatch and providers to help feed into the checkpoint submission and provide an early opportunity to shape the direction of the STP
- Ideas from the first session included the Peoples Health Charter which is an important part of our STP moving forward.
- Hosted two workshops with communications leads from across sectors to help co-design the engagement strategy
- Co-designed the engagement strategy with Healthwatch chairs
- Hosted sessions with clinicians to get their input into the priorities and delivery areas, ensuring our workforce is a driver and owner of change
- We ran a market stall event for our core partners (20 July) to showcase the range of work which is happening across North West London
- Created a core narrative covering our health and social care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – ensuring it is in patient- focused and in accessible language

Communications and Engagement (2) – Engaging on the checkpoint submission (July – October)

Throughout the summer and the autumn we are engaging through:

Face to face meetings:

- We have organised a programme of traditional town hall style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents associations to ensure that we get real input from the local community
- The events are a mix of presentation, Q&A and table workshops to allow as many attendees as possible to participate in the discussion. The events are genuinely collaborative with most being hosted and led by a senior clinician and a senior Councillor from the borough
- Feedback from all these events is provided to both all those who attend and to the team producing the STP to ensure it is reflected in this final iteration of the plan.

An online engagement tool:

- On the 17 August we launched an online engagement tool with the specific aim of targeting those residents who want to contribute to the discussion but don't have the chance to attend a public meeting.
- Since launching we have had 1,257 visitors to the site with 150 comments and 110 registering for further information and updates.
- We supported this activity with Facebook advertising which has so far been seen by over 16,000 residents through either Facebook or Instagram.

Public outreach:

- We know there are groups out there who won't proactively engage with us and so we have launched a programme of public outreach with the aim of getting to those harder to reach groups.
- Utilising the stakeholder lists held by both local government and the health service, and lists provided by Healthwatch and other partners, we have so far contacted over 500 groups. These are as diverse as faith groups, community organisations and charities.
- We are also surveying residents and holding pop up stalls where we can talk about our plans in supermarkets, libraries, stations and community centres

With staff & partners:

- Our best advocate for the STP is our staff, spread across multiple locations and in a range of different roles. Each of our partners – whether in health or local government – is working up plans for specific staff engagement.
- Across the STP footprint we are running a series of workshops with clinicians and local government officers to engage them on the STP
- STP updates are already a regular staple of all our internal communications materials through internal newsletters and bulletins, weekly/monthly updates from Chief Executives and Chief Operating Officers, and online through our intranets.
- We are also working in tandem with our GP federations to engage primary care providers

Some highlights of our activity

Public meetings

- 20 September – Ealing town hall style event
- 26 September – Brent town hall style event
- 27 September – Hounslow town hall style event
- 03 October – H&F town hall style event
- 05 October – Westminster public meeting (HWB)
- 11 October – Harrow town hall style event
- 12 October – RBK&C town hall style event

Online

- 17 August – Online engagement tool launched
- Over 1,250 visitors to the site already
- Supported by Facebook advertising
- Over 16,000 people have seen the ad either on FB or on other FB platforms (e.g. Instagram).
- FB says 419 have taken action after seeing it (this is either them clicking through, sharing, commenting, liking etc.).
- It says 106 people have clicked through to the tool.

Public outreach

- Over 500 organisations have been contacted with meetings now being set up
- 05 September – Ealing PPE
- 06 September – NW London PPRG
- 10 September - Stall at West Ealing Festival
- 14 September – Lay Partners Forum
- 15 September – Healthworks Information Exchange, Dalgarno Community Centre
- 21Setpember – Stall at Kensington Central Library

Communications and Engagement (3): Co-design of services and engagement on implementation and delivery

A core principle of all our activity is that engagement is continuous and does not stop with this iteration of the plan. To make the STP a success we need to be clear on how we will engage on implementation and delivery and ensure our residents are involved in the co-design of services and any service change. Over the next twelve months following publication of the plan we will:

- **Hold regular public meetings –** building on the series of town hall style events we are running for this iteration of the plan we will look to hold regular update meetings where we can discuss latest developments, take questions and sign post people as to how they can get involved in the specific delivery areas.
- **Continue our online engagement –** given the popularity and range of issues which have been raised through the process so far we will continue to use this tool to ensure a continuous dialogue with the wider public across the eight boroughs.
- **Continue with the public outreach –** it will take time to work our way through the diverse groups and communities that make up our STP footprint and we want to ensure that we talk to as many as possible and give them an opportunity to get involved in the implementation and delivery of the plan.
- **Staff –** and of course staff, whether in local government or the health service, will remain our best advocates for the plan and so across all our partners we will continue to engage with them through all available outlets.

Just as importantly we want to ensure full participation and co-design in all five delivery areas and the projects and programmes that sit within them. We will:

- **Patient involvement –** we will ensure that we have patient representation across the five delivery areas and that patients are involved in the co-design of services and any service change.
- **Specific engagement –** we will work with those patients to design engagement plans for those areas of work, using a combination of the methods set out above.
- **Consultations –** Where specific programmes or projects require consultations, as set out under section 14Z2 of the NHS Act 2006, we will carry those out.
- **Equality Impact Assessments –** Where specific programmes or projects require equality impact assessments, we will carry those out.

NW London STP – Feedback from the public

Summary of public engagement for the STP to September 30 2016.

The public engagement strategy for the NW London STP built on tried and tested approaches, and also tested a new interactive online offer to try and reach new audiences, particularly younger people and infrequent users of the NHS. This led to a four pronged approach, which can be summarised as:

1. Face to face meetings: these include a programme of traditional town hall style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents associations to ensure that we get real input from the local community. This engagement also includes briefings with MPs and local authorities, and through formalised routes such as overview and scrutiny committees and CCG governing bodies.

2. Public outreach: We know there are groups out there who won't proactively engage with us and so we have launched a programme of public outreach with the aim of getting to those harder to reach groups. Utilising the stakeholder lists held by both local government and the health service, and lists provided by Healthwatch and other partners, we have so far contacted over 500 groups. These are as diverse as faith groups, community organisations and charities. We are also surveying residents and holding pop up stalls where we can talk about our plans in supermarkets, libraries, stations and community centres

3. With staff & partners: Our best advocate for the STP is our staff, spread across multiple locations and in a range of different roles. Across the STP footprint we are running a series of workshops with clinicians and local government officers to engage them on the STP. Updates are already a regular staple of all our internal communications materials through internal newsletters and bulletins, weekly/monthly updates from Chief Executives and Chief Operating Officers, and online through our intranets.

4. An online engagement tool: designed to engage with all sections of the public, and be fully accessible on computers, tablets and phones. A 'survey' version was also included, linked to the same system, for face-to-face conversations during community engagement. Since launching we have had over 1100 visitors to the site and 150 face-to-face surveys with more than 300 comments received. Over 100 people have signed up for further information and updates. We supported this activity with Facebook advertising which has so far been seen by over 18,000 NW London residents through either Facebook or Instagram.

Summary of Feedback Received

We are grateful for the time the public and stakeholders have given to feedback on the STP, and this feedback can be categorised into two distinct areas. First, there was a clear demand from those we most regularly engage with - for example stakeholders like Healthwatch, established patient groups and 'more informed' individuals - for greater clarity on 'technical' issues relating to the STP. These included its background, scope, legal standing, governance, timelines, implementation plans and likely impact on future funding for the NHS and local authorities. Other issues raised included engagement and consultation plans and how the STP related to future NHS organisational forms, such as accountable care partnerships. Answers were provided wherever possible, and the draft STP was made publically available in response to the obvious appetite for more information. The second area was more subjective, and related to the five STP delivery areas in the NW London draft document. The vast majority of this feedback was received via responses from the online engagement and its face-to-face survey mode, as public meetings tended to be dominated by the first category above. All comments received can be viewed online, and there is some evidence that by using this approach we have successfully reached out to new audiences, as well as receiving useful service specific feedback to help shape local and at scale plans which fit under the STP. This is summarised below.

Online engagement with our residents

Online engagement

Historically, in the NHS there are known proactive voluntary organisations and residents who are readily engaged with. While face-to-face meetings with hard to reach groups and stands in shopping centres and local festivals reach more people, who do not normally have the time to spare during work hours to offer their opinions, there is still work to be done to reach younger and working members of our communities.

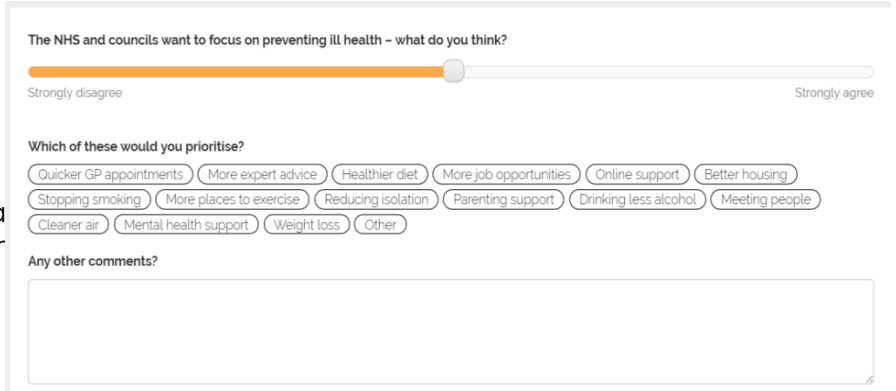
To try and target this audience we have developed an online engagement tool. This is an innovative and exciting way of reaching residents online and via social media and It sits along-side tried an tested methods of engagement.

To-date, of those who have used the online tool, the largest age-bracket is the 25-34, with those aged 35-44 being the second largest age group to respond. This means we are reaching a younger audience, who are not normally engaged with.

The online tool

Participants have the option to comment on five key areas that we are looking to improve across NW London:

- Preventing ill health
- Long term care
- Care for over 65s
- Mental health
- Quality of care



Each area has a simple outline of what we would like to achieve and a opportunity for respondents to comment on whether they agree with th priority, choose what we should be focusing and provide further comments.

The online engagement can be used remotely via an iPad so face-to-face surveys in the community are automatically uploaded to the database, ensuring consistency. The online survey can also support multiple languages via Google Translate.

Online engagement with our residents

Feedback

Respondents viewed our suggested priorities positively, with suggestions being made for:

"Bed-blocking in hospitals by elderly, infirm patients is a major problem for the NHS and there needs to be a lot more provision for alternative care outside of hospitals."

"More resources need to be put into enabling the elderly and those with long-term conditions to remain independent and to stay well at home. This requires a lot of joined-up care across the health/social care interfaces."

"***Staying well at home*** and in a familiar environment is very beneficial for the elderly both mentally and physically."

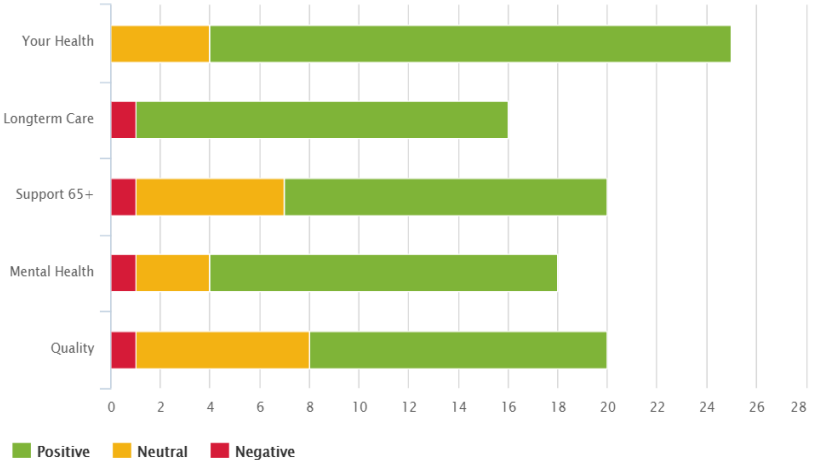
"Although you want people to exercise but health centres are still very expensive. For some people it is hard, almost impossible to exercise outside, so please make more places available at an affordable price for people to exercise."

"***Support the carers of mental health patients*** by educating them and letting them be involved in care plans."

"***Living (and dying) at home*** is always the preferred course. It also generally saves money (compared to hospital 'bed-blocking') but it would probably be worth bringing back care homes for those unable to look after themselves and who need more help than just a quick daily/twice-daily visit."

"***Housing is a key issue*** but I'm not sure how much you can do to resolve it."

"Better use of volunteers, particularly for reducing isolation."



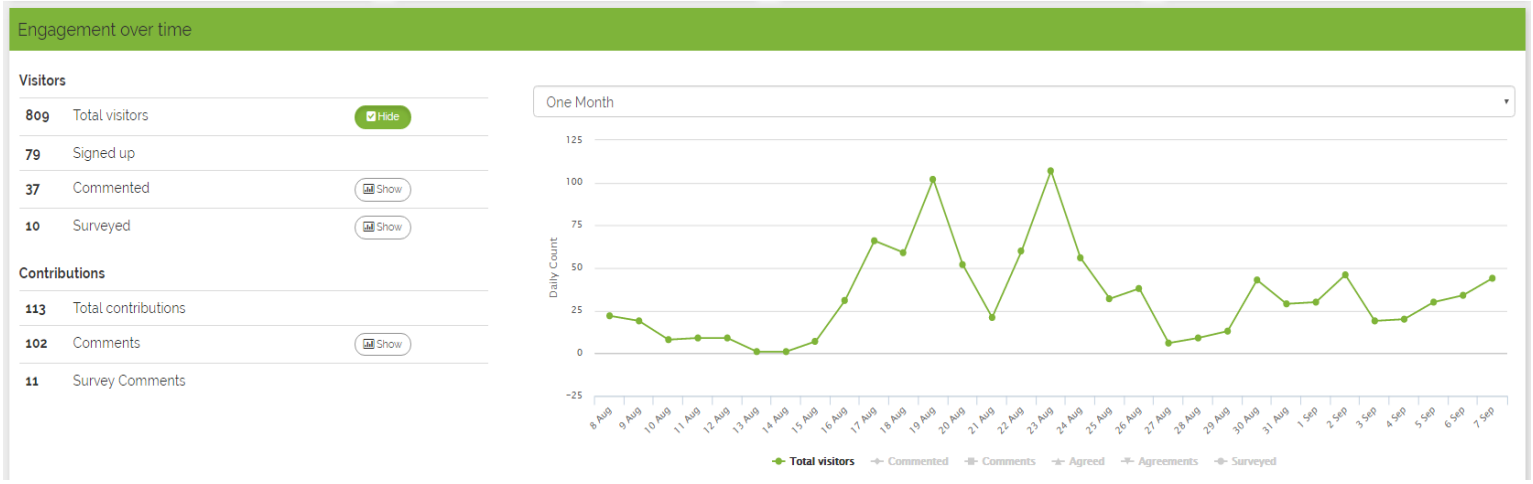
"***Healthy lifestyle and mind set is important***, how about offering a referral to a course that involves learning to cook healthy food, how to do basic fat burning and cardio exercises in your own home/outdoors, how to relax/meditate/mindfulness, how to find fun, manage stress, meet others."

"Quicker access to psychologist and physiatrist is so important. I have been hospitalised twice -2 months each time in a mental hospital- with serious depression which drove to tempted suicide. When I start getting depression I refuse asking for help just to hit rock bottom and my family suffer when I'm at those stages."

"For over 65s, I see a huge need to join up physical and mental health with social care. A 76 year old neighbour has diabetes, crippling anxiety and no fridge and is unwilling to switch on hot water for financial reasons. A perfect example of why response needs all 3 areas to work together."

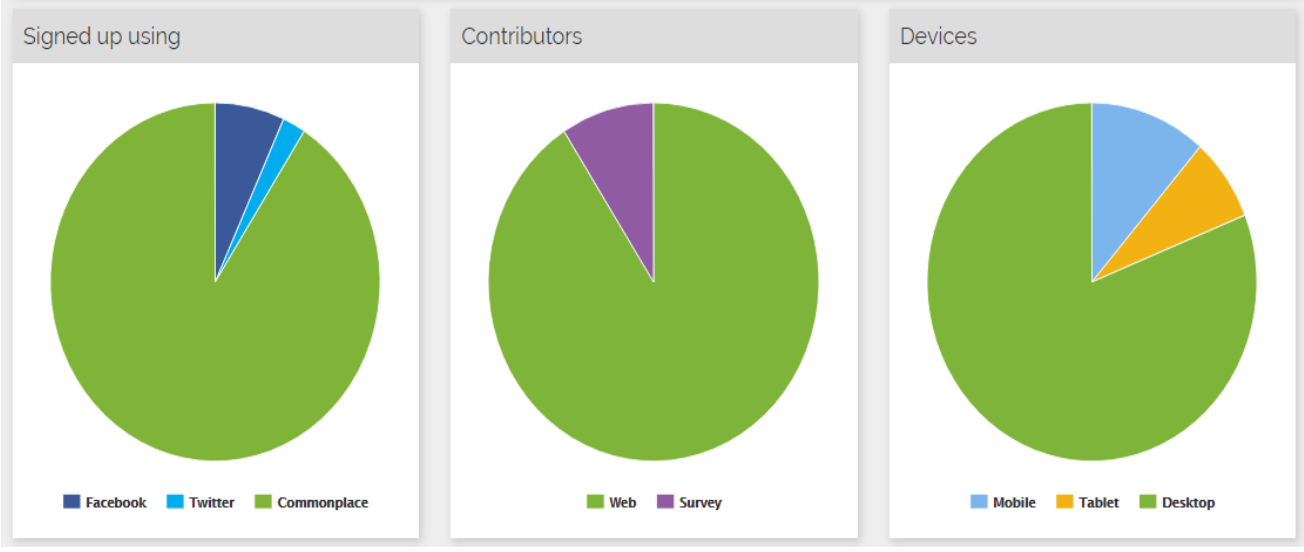
Online engagement with our residents

Dashboard



The information is presented in a dashboard which allows our engagement team to review and arrange face-to-face meetings with audiences whose comments are not represented so far.

The dashboard also shows how people arrived at the site, e.g. through social media channels, face-to-face surveys from our engagement team or by email. This information will give a useful insight into how effective our current engagement channels are.



NW London STP – Online and Survey Feedback

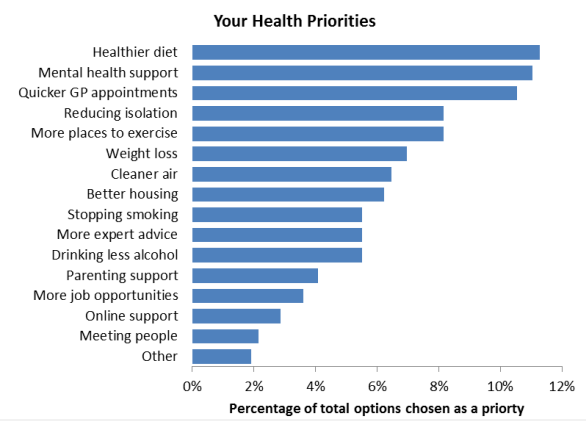
Online and survey feedback

The online and face-to-face survey option had three parts to it: an interactive 'sliding scale' for individuals to indicate their level of support, or not, for a particular delivery area; a number of buttons which could be selected to show favoured priorities within a delivery area and; a free text box for respondents to set out their views as they saw fit. The free text comments often covered a range of topics and points, as well providing personal experience and views on problems with current services and opportunities for improvement.
The analysis below sets out the key quantitative feedback based on the most popular priorities selected for each delivery area and; summarises the key themes drawn from the qualitative free-text responses.

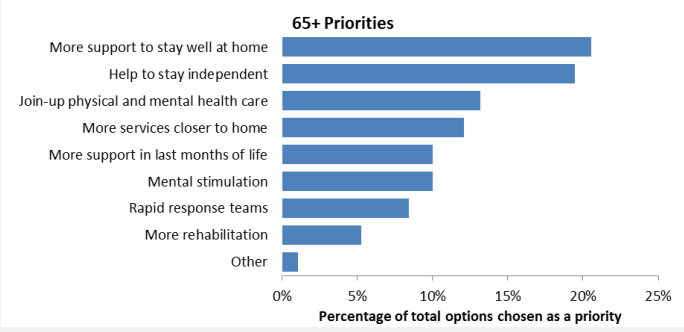
Quantitative feedback

Under each delivery area, respondents were invited to select one or more priorities from a range of options.

Public priorities



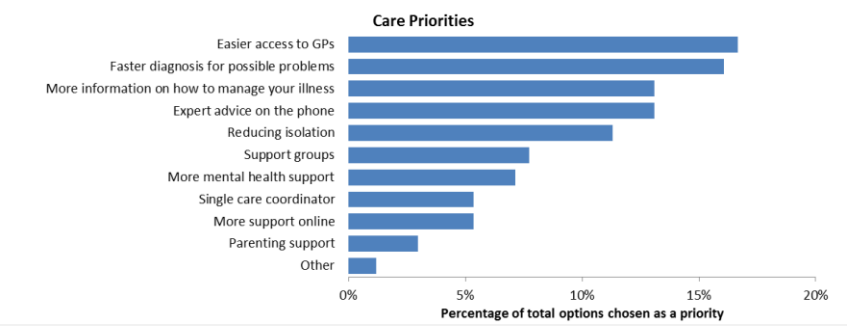
Your health is affected not only by physical illness, but by the environment and communities you live and work in. NW London wants to support the public to have a healthy life. When asked what the public would want to prioritise when it came to improving their health and wellbeing, a healthier diet and mental health support were the options that were most often chosen.



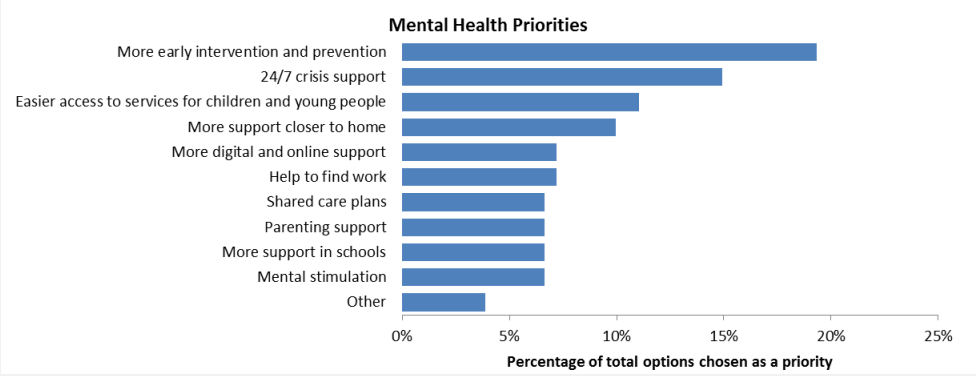
NW London is home to over 300,000 over 65s, and more than 5,000 of these residents have advanced dementia. NW London wants to improve care for older people. When asked what care they would prioritise for over 65s, the options that were most often chosen were more support to stay well at home, and help to stay independent.

NW London STP – Public Priorities Continued

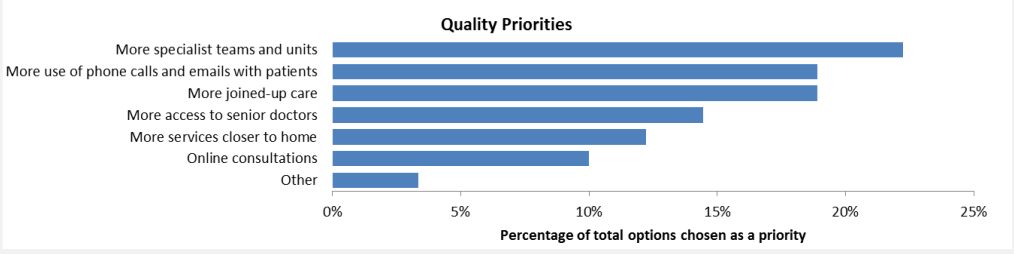
Public priorities



NW London wants to make sure that everyone who needs lifetime or long term treatment or care for illness, disease or disability, receives consistent high quality care and gets the support they need to help manage their condition. When asked what care they would prioritise for people with long term needs, most respondents prioritised easier access to GPs and faster diagnosis for possible problems.



NW London wants to reduce the impact of mental health needs or a learning disability. In NW London, we currently have over 260,000 residents with mental health needs or learning disabilities. Those responding to this section of the survey mainly prioritised early intervention and prevention, as well as 24/7 crisis support.



NW London wants to provide safe and high quality services. Whilst the vast majority of care is delivered to a high standard, we know there is more we can do.

To make local health and care service more modern, safe and effective, most people responded that they would prioritise more specialist teams and units, and more use of phone calls and emails with patients.

NW London STP – Qualitative Analysis of feedback from the public

Qualitative analysis

The qualitative online and face-to-face survey responses varied widely, from the very personal to detailed system analysis. Some gave single sentence comments, others covered multiple topics over many paragraphs.

Separating these comments into categories is challenging, but it has been possible to group the main points raised under 11 main themes, which are set below in order of occurrence, highest first.

- More information and support*
- Funding and structural concerns for NHS and local authorities*
- More integrated support and services
- Better GP services and access
- Importance of mental health*
- Power of positive communities*
- Service and quality concerns
- Benefits of technology
- Better environment
- Faster treatment*
- Impact of carers and volunteers*.

*joint positions.

The most commonly mentioned themes which could be extracted from the comments were:

- better information and support
- funding concerns and;
- more integrated care and services.

There were three themes which featured in comments across all five delivery areas, which were:

- better GP services and access;
- funding concerns and;
- importance of mental health.

NW London STP – Qualitative Analysis of feedback from the public

Feedback for each delivery area

Delivery area 1 – radically upgrading prevention and wellbeing
The prevention and wellbeing area was very popular and provided the largest number of comments which could be themed. This is perhaps not surprising as this delivery area provide wide topics for comment, from air quality, to lack of amenities, to the power of closer communities. An example comment is:

"There should be more focus on helping people stay in the same communities as their elderly parents, so that children are able to care for their elderly parents, particularly if they suffer with multiple health problems. This will help with reducing the need for social services providing Carer's and also help the elderly to have a motivated active and social life which would also reduce NHS costs. Communities that can support themselves by encouraging relatives to look after their elderly by offering incentives such as housing to stay in the community. Loneliness leads to bad physical and mental health. (sic)."

The most common themes for this delivery area were: **funding concerns** (linked often to lack of investment in local facilities and communities); **a better environment** and; **more information and support**.

Delivery area 2 –eliminating unwarranted variation and improving long term condition management
This area contained the least amount of feedback which has been themed, perhaps reflecting that fewer respondents felt qualified to comment unless they or close relative had a long term condition. This supposition is supported by the fact that those of respondents who chose to register and provide more detail, only a small percentage identified as having a long-term condition.

The most common theme for this delivery area was for **more integrated support and services**, probably reflecting the multiple care needs for those with one or more long-term conditions. As one respondent said: *"I am completely lost in this system. It is seems over complicated without continuity with medical advisors "*.

The next most popular theme was **better information and support**, as reflected in this comment: "*Support groups are the answer more hands on than when I went to Ealing hospital. In church halls for over 65s. It's a very friendly group rather than the hospital which is very cold. This support group for my arthritis is a community treasure we should value.*"

The third most popular theme was for **better GP services and access**.

Delivery area 3 – achieving better outcomes and experiences for older people
Feedback received in this delivery area was, as with delivery area 4, often very personal, as demonstrated by this quote, which also shows the importance of improving and joining-up care: "*I am 88 and have no one to look after me when my daughter is away. My house is very cold as I can't afford to heat my house all the time.*"

NW London STP – Qualitative analysis of feedback from the public cont.

More integrated care and services was the stand-out theme in this delivery area, with a very equal spread across the other themes. The impact of carers and volunteers, funding concerns and better information and support all measured equal second in popularity. Service and quality concerns, power of positive communities and importance of mental health all ranked equal third. Here are two more comments which bring the themes to life:

"I'd like to see holistic support tailored around the person. People need to be recognised as individuals and the relationship between services (be they provided by whoever) should be consistently high quality with the emphasis of developing and maintaining the individual's trust in services and be respectful and dignified. People need to be involved in their care and support."
"For over 65s, I see a huge need to join up physical and mental health with social care. A 76 year old neighbour has diabetes, crippling anxiety and no fridge and is unwilling to switch on hot water for financial reasons. "

Delivery area 4 – improving outcomes for children and adults with mental health needs
This delivery area provided the second highest number of comments which could be themed and again, some very personal and powerful contributions:

"Quicker access to psychologist and physiatrist is so important. I have been hospitalized twice -2 months each time in a mental hospital- with serious depression which drove to tempted suicide. When I start getting depression I refuse asking for help just to hit rock bottom so to end my life. (I don't know why though, but that's how I feel). My family suffer when I'm at those stages."

Overall, better information and support was the stand out theme, as shown by this comment: "*Support the carers who care for the mental health patient by educating them and let them be involved in the care plan for the cared for person*".

This theme was almost twice as common as the next popular, concerns around funding, followed by calls for more integrated support and services. These themes are drawn out in the following comment: *"We need more psychologists! However, this will obviously cost more money, but if people in need don't get psychological help then they will have more episodes and this will cost even more. They also need support for housing and disability support allowance is not enough. Also not just parenting support. But also carers need support. 24/7 crisis support need is important and so are more places of safety in the community line. We have an emergency line in Ealing with clinical support and social care follow up. 03001234244. Any line has to have both these requirements (clinical + social care)"*

Delivery area five – ensuring we have safe, high quality sustainable acute services
Interestingly, this delivery area attracted the only comments related to the benefits of technology, which was the most common theme for this section. As one respondent wrote: *"GPs could also help by increasing access to telephone, video and email consultation.*". Funding and structural concerns were, perhaps unsurprisingly for this delivery area, a close second and closely followed in third place by calls for more integrated support and services. Here are two further examples which highlight the public's views of how we can improve:
"Being under outpatient care of two separate hospitals it would be good if they communicated with each other. Currently correspondence I receive from one or other is photocopied by me and delivered when attending an appointment. This is archaic method of communication."
"Integrating health and social services would provide better care at reduced cost once IT systems are integrated. Workers can then work from shared premises."

Conclusion
This feedback will be shared widely across the NHS and local authorities to help drive and shape our future plans for health and social care in NW London.

Appendix E: NWL Sustainability and Transformation Plan
You said, we did – Response to patient and organisation feedback on the 30 June Submission

Appendix E: You said, we did – response to patient and organisation feedback on the 30 June Submission

One of the key principles of our engagement process is that we listen and then act upon the advice we receive, feeding back as much as possible. Below we set out the initial feedback we have received through written submissions, public meetings, via the online engagement tool and from questions raised through public outreach in relation to the 30 June checkpoint submission. Given the large volume of feedback we have received the below list is not exhaustive, far from it, and we have concentrated our time now on reflecting as much of that as we can in the document itself. We will be producing a fuller feedback log which we will release and will set out clearly how we have addressed all the comments we have received.

Theme	Organisation	Feedback	Changes/response to/in STP document
Governance	The Hillingdon Hospital FT	Query around board responsibilities on receiving the final STP version	The formal governance approach is in the process of being agreed across CCGs, local authorities and providers.
	Hillingdon Partner	Query around board responsibilities as the draft goes through local approval processes (consistent form of words e.g. supporting/endorsing)	See above
	West London CCG	Clarification on governance – STP implies engagement rather than decision-making	The STP has been updated to reflect the governance development since the June submission. The decision making powers of the JHCTG remain unchanged.
		Programme of work across the 8 CCGs would be best served by a standard decision-making pathway rather than a structure for each programme.	The governance structure of the STP can be seen on page 21 of the Delivery Plan paper.

Appendix E: Response to patient and organisation feedback

Theme	Organisation	Feedback	Changes/response to/in STP document
Financial	Central and NW London FT	Concerns around spend and savings for mental health against the national requirements	The five year forward view for mental health has been incorporated into the Mental Health chapter for the October submission.
	Hillingdon Partner	Further information about how the plan will lead to access and allocation of funding	Project delivery plans are being developed which will set out the relevant financial information.
	Chelsea and Westminster FT	Prevention and H&WB target will be challenging to realise within 5 years	Project delivery plans are being developed for prevention schemes.
	Hounslow CCG and LA	Establishing the origin of the £110 million of investment that has been linked to LAs under DA1 The £145 million LA budget gap in the STP has been underestimated given the time frame	The June submission of the STP included the references for prevention opportunity, which included the HLP Report and the Prevention Report from the WLA. Local authorities have commissioned work to review the social care gap. This will feed into the STP's Strategic Finance and Estates Group which will update the STP's finances where required.
		Financial resource required for extra sheltered housing and care home places has not been included.	Delivery plans for projects in Delivery Area 1 include requirements for sheltered housing and care home initiatives and will set out existing resources and resource requirements.
	Brent Patient Voice	Too much financial detail is missing from the checkpoint submission. It's impossible to properly analyse the plan without all the figures and the workings which sit behind them to understand whether this is really sustainable.	The financial data has been included in this iteration of the plan to demonstrate how it will be sustainable

Appendix E: Response to patient and organisation feedback

Theme	Organisation	Feedback	Changes/response to/in STP document
Financial	ICHT	Given the scale of our combined financial gap over the five years greater assurance is required on the return on the investment in the work programme to close the £1.3bn gap, the phasing of realising the net savings outlined and the process to mitigate significant risks.	A robust programme governance process has been established through the Delivery Areas to manage the risks associated with delivery of the constituent projects. Each project team is in the process of undertaking a detailed financial analysis profiled to their delivery plan and will maintain a risk and mitigation log. This approach is outlined in the NWL Delivery Plan.
		We have a clear internal sign off process for our STP financial data which we submit through the Finance and Activity Modelling Group (FAM). Understanding the upwards approvals process in generating the combined footprint level financial analysis is necessary to contextualise the financial messages and promote greater ownership of the numbers behind the STP's financial position.	As well as the Financial And Activity Modelling Group the health Chief Finance Officers are meeting weekly for this reason. We have also established a finance and estates working group that reports into the Joint Health and Care Board.
Engagement		The engagement document provides a helpful position statement and sets out some immediate actions. There is scope to develop this more fully into a strategy which clearly signposts to staff and the public areas where their input will add the most value, identifies measures of success and the mid to longer term opportunities for engagement throughout the period that the STP covers.	An updated communications and engagement strategy is included in this version of the STP. At it's core is a belief that this is a continuous and transparent process that will run across the five yeas of the STP
	RBKC	Public engagement needed to be enhanced, perhaps by production of a summary document that the public could understand.	A public-friendly presentation has been widely circulated which can be adapted for local needs. The online version is also available to the public. We will speak to RBKC to address this further.
	Healthwatch	A number of Healthwatch colleagues, in particular from Ealing, raised issues around lack of engagement on the implementation of SaHF, most notably for Ealing and Charing Cross Hospitals. Engagement activity must not ignore changes to these two hospitals as it is of key concern to residents.	The engagement activity to date has focussed specifically on the overarching principles that sit behind the plan and how we tackle the challenges we face in NW London. We agree that it is essential to engage with residents about developments at both Ealing and Charing Cross Hospitals as we move towards having a IMBC, we will start that engagement and we will look to work with Healthwatch to ensure we engage with as many residents as we can.
Evidence base	Brent Patient Voice	There needs to be a proper evidence base for the out of hospital strategy.	An independent piece of work was commissioned by five of our local authorities to assess the evidence base for moving more services to an out of hospital model.

Appendix E: Response to patient and organisation feedback

Theme	Organisation	Feedback	Changes/response to/in STP document
Policies	Hillingdon CCG	CCG does not support current wording of primary care standards in the STP – request change to wording.	Please see revised Primary Care chapter
	Chelsea and Westminster FT	Harness NWL's capacity in research and services	The academic health science network attends the NW London Strategic Planning Group (SPG) and has been involved in the development of the STP. It is also involved in the mobilisation of the Delivery Areas.
	Hounslow CCG and LA	There are not enough plans around wider determinants of health, particularly housing, social isolation or community resilience. There should also be an approach to tackling underperformance in primary care.	The Wider Determinants of Health project was a new initiative in June 2016. A project delivery plan is being developed which will provide further details around deliverables and resources. There will be an updated Primary Care chapter.
Nomenclature	NWL CCGs Strategy & Transformation	'7 day discharge' or 'expanding common discharge' rather than introducing new term 'single discharge' as in STP	The STP October submission has been updated with this change.
Local & Central plans	Ealing CCG	Have a central response as to why local plans are not being published	The local plans were an important part of the early work in developing the NW London STP. Where there has been an interest in that local plan, we have made it available, for example the Ealing plan is available online
	Hillingdon Partner	Will the final version of the STP have local chapters?	The local plans were an important part of the early work in developing the NW London STP. NHSE have not asked for them to be included in the final version, but the plans ultimately shape the priorities within each borough
	Hounslow CCG and LA	Local services programme should be emphasised	The Local Services Programme is a critical component of delivering the STP as its projects fit under 3 of the Delivery Areas. For the October submission of the STP we will also submit detailed implementation plans for each delivery area, this will set out in more depth the activities that will be undertaken, including through the Local Services Programme.

Appendix E: Response to patient and organisation feedback

Theme	Organisation	Feedback	Changes/response to/in STP document
Communication	Chelsea and Westminster FT	Communicating impact to the population and the workforce rather than just a plan	There is agreement on the importance of communicating with the population and our workforce in NW London. The STP will only be successful if those who live and work in NW London own, understand and are involved with the STP. A series of engagement events and activities are taking place which will set out the impacts to residents and staff.
	West London CCG	Reference public meetings	We will update the STP to reflect the public meetings and online engagement as these activities have developed since 30th June.
		Information for staff is essential	There is agreement on the importance of providing information to staff. We have a programme of communication and engagement activities planned across organisations in NW London.
	Ealing LA	Ealing has not signed up to the STP (due to concerns around acute configuration) and wants this to be emphasised	We have a strong relationship in NW London with all eight councils and the health service working together to deliver the best care and support for all our residents, particularly around prevention and out of hospital services. That relationship means we are open and honest about where we disagree. We will continue to work with both Ealing and Hammersmith & Fulham councils on all the areas we do agree on, mainly local services and our out of hospital strategy to deliver joined-up health and social care for our residents.
		Ealing and Charing Cross hospital plans have not been clearly explained	We have a strong relationship in NW London with all eight councils and the health service working together to deliver the best care and support for all our residents, particularly around prevention and out of hospital services. That relationship means we are open and honest about where we disagree. We will continue to work with both Ealing and Hammersmith & Fulham councils on all the areas we do agree on, mainly local services and our out of hospital strategy to deliver joined-up health and social care for our residents.

Appendix E: Response to patient and organisation feedback

Theme	Organisation	Feedback	Changes/response to/in STP document
Timelines and overlaps	Chelsea and Westminster FT	NHSEs approach to reviewing services aligns with STP checkpoints in October which should be addressed in DA5	For the October submission more detailed implementation plans will be included. This will set out further detail on Delivery Area 5.
		There are significant overlaps with productivity and improvement in acute services and the SaHF planning workstream.	The existing Provider Board which oversees the productivity work, and the Implementation Programme Board which oversees the acute transformation work are now merging into a STP Delivery Area 5 Board which is currently in planning and handover stage. This Board will help us to ensure that productivity work programmes continue to be aligned with SaHF programmes of work. The existing Boards have representation from NWL acute and community providers, and the productivity piece of work in particular is provider-led. The productivity work programmes are overseen by a Chief Transformation Officer who is based alongside the SaHF team. Some overlap is intentional, as the productivity work is more achievable in a shorter timescale than the larger scale transformation work associated with the hospital reconfiguration.
		The timeline for estate enabled benefits (acute) is outside of the 5 year period of the STP.	The assurers for the acute transformation work have requested that the team produce both an accelerated timeline as well as a traditional timeline for this piece of work. Under the accelerated timeline, some elements of the acute transformation will be delivered within the five year period of the STP. This timeline is currently in process of being assured and will be finalised in early 2017.
Lay Partner Feedback	Lay Partner Meeting	Increase in community centres; better access to counselling and therapy; education around health and wellbeing; A proactive approach to long-term care; review of medications for over 65s.	All of these areas are integral to the Delivery Areas outlined in the STP. Further detail will be set out in the implementation plans which will be included in the October submission.

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

Agency Spend Controls from NHS Improvement

Executive summary:

NHSI have issued recent instructions to Trusts as they want to ensure that boards are doing all they can to take control of agency spending and are implementing further reporting requirements of Trusts as detailed in the attached paper. They will be holding further regional workshops to ensure that agency spending forms a key component of STP discussions. STPs will be expected to ensure agency rules and controls are implemented to reduce excess costs and provide services within the systems control team.

There is an expectation that Boards are systematically holding executive directors to account to reduce excess costs associated with agency spending, informed by high quality information. A self-certification checklist is required to be completed with signed off by the Chair and Chief Executive.

The attached report details the Trust's progress on reducing agency spend.

Quality Impact:

Financial impact:

Removing reliance on expensive agency workers will continue to reduce agency spend in the Trust.

The Trust was set a target of £34.6m agency ceiling spend compared to £52m in 15/16. Current performance against the target is that we are spending below the ceiling. A recent report from NHSI London has shown that Imperial is one of the 3 trusts with the lowest agency spend relative to their ceiling (ranked out of 36 Trusts).

Risk impact:

Failure to find suitable applicants to fill vacant shifts/roles within the capped rates.

Recommendation(s) to the Committee:

Approve the Self Certification Checklist

Trust strategic objectives supported by this paper:

To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.

Author	Responsible executive director	Date submitted
Dawn Morris	David Wells	24 November 2016

Agency Spend Controls from NHS Improvement

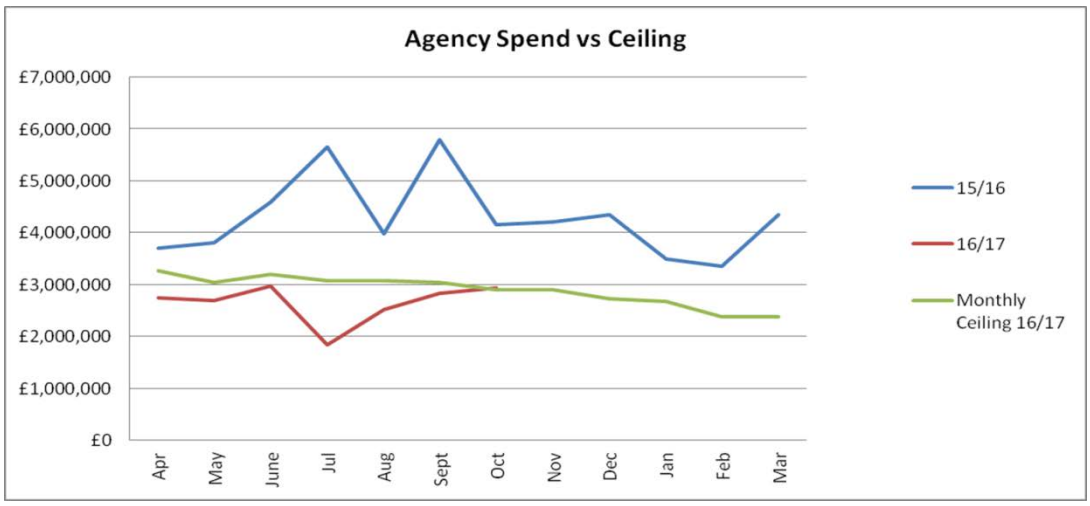
1. Introduction

NHSI introduced agency rules, spend targets and agency caps a year ago across all staff groups. However, as agency spend in the NHS is around £250m a month, NHSI want to ensure that boards are doing all they can to take control of agency spending and are therefore implementing further reporting requirements of Trusts as detailed in the attached paper. From November NHSI will be sharing data on agency expenditure (in relation to ceilings and total workforce costs) for all trusts in the region.

On top of these controls the Trust was set a target of £34.6m agency spend ceiling for 15/16. Table 1 below shows our performance against the target.

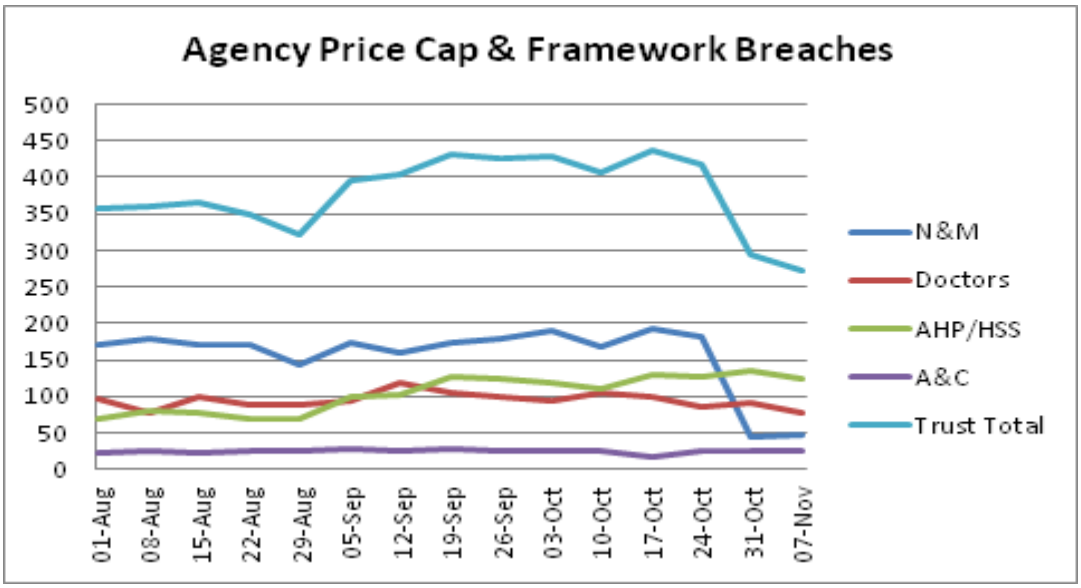
A recent report from NHSI London has shown that Imperial is one of the 3 trusts with the lowest agency spend relative to their ceiling (ranked out of 36 Trusts

Table 1



The Trust has reports on a weekly basis any agency shifts which have been breached the rules. Table 2 shows the number of breaches reported in the last three months.

Table 2



2. Additional Controls from NHSI

Below is a summary of the actions required by the Trust and the timeframes as detailed in the letter of 17th October from Steve Russell, Executive Regional Managing Director (London) NHSI.

Action	Timetable	By Whom	Status
Monthly agency spend broken down by cost centre/service list	By 12 pm on 24 October submit to Finance inbox	Finance	Actioned
• List of 20 highest earning agency staff (anonymised) • List of agency staff that have been employed for more than 6 consecutive months (anonymised)	By 12 pm on 31st October	HR to compile – information to be confirmed by Divisions/Corporate areas	Action
Board, with CFO, HR, Nursing & Medical Directors to discuss and complete agency self-certification checklist	30 November Appendix 1	HR to complete	Attached for sign off
Chief Executives to personally sign off on: • All shifts by individuals costing more than £120 per hour • All framework overrides above price cap	Retained in Trust does not need to be submitted to NHSI	Agreed these shifts will be authorised by the Divisional Directors and shown on the weekly reports submitted to Executive Directors	Actioned
Approve from NHSI in advance of: • Signing new contracts with agency senior managers where the daily rate exceeds £750, including on costs • Extending or varying existing contracts where the daily rate exceeds £750, including on costs or incurring additional expenditure to which they are not already committed	From 31st October Submit to NHSI agency rules mail box	As yet we do not have any new or existing workers who exceeds the £750 per day.	

3. Action being taken to reduce Agency Spend

The Trust has reviewed all the posts which breach the price caps or use of non-framework agencies over the last year. From this a significant number of agency workers assignments have ended.

The new CCP Clinical Staffing Framework which went live on 31st October has seen a dramatic drop of beaches within the nursing & midwifery staff group – from an average of 183 per week to 43 November. This is a great achievement and means that we are paying

£3-5 less per hour for these shifts. The current breaches are from specialist areas where the frameworks are unable to supply or to supply at the agreed rate, however, it is expected that this will reduce down shortly as well as the recent recruitment of ENPs in the UCC will reduce the need to high cost agency workers by December.

The Trust has introduced an administrative & Clerical & AHP bank from 17th October and we are already an increase in bank workers for this group of staff. Further work will be carried out to attract more workers onto the bank.

A review of bank rates for medical locums will be carried out again with an aim to increase the number of locum doctors working via the bank to reduce costly agency spend.

We are also working as part of the North West London Bank & Agency Collaborative Project to align our processes with an aim to increasing bank fill by releasing our vacant firstly to our own bank workers and then to the wider NWL bank community before approaching an agency to fill the shift.

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	Yes, weekly price cap and framework braches are reviewed by all executives	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.		Directors have a clear financial objective. It is not specific, however the Trust target is implied within this and tracked as part of the workforce reports.
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Agency spend and compliance to agency rules are discussed at the monthly Executive Operations Meeting	
4	We are not engaging in any workarounds to the agency rules.	We are not engaging in any workarounds to the agency rules	
	High quality timely data		
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	Agency usage is monitored fully in the Trust and reported on a monthly basis, including performance to the agency spend cap. The areas of high agency usage are linked in with difficult to recruit areas.	
	Clear process for approving agency use		
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	Yes for most areas	Not fully for Medical Locums, devolved to Divisions will centralise with roll out of Healthroster to medics
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	Agency request pocess detailed on the source (intranet)	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	Yes approval for agency staff requires approved by senior staff. Most expensive clinical shifts are approved by the Divisional Directors	
	Actions to reducing demand for agency staffing		
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Agency spend and usage covered discussed finance and performance meetings within Divisions and corporate areas	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	Functional bank for N&M and medics. Recently Implemented for admin & clerical staff	Bank being developed for Allied Health and Scientific roles
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.		Currently 4 weeks, moving to 6 weeks by 1st January published roster
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	Time to Recruit from receipt of ERAF to offer is 40 working days - standard for most London Trusts.	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	Yes	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	Yes	
	Working with your local health economy		
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	Yes	
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	The Trust is part of a North West London Bank & Agency Collobrative project to work together to tackle agency spend. The Trust also works with framework providers to obtain the best rates from agencies	

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	30 November 2016

NHS Improvement: 2016/17 quarter 2 finance and operational performance report

Executive summary:

NHS Improvement has released the quarter two finance and operational performance figures for the provider sector. These figures cover the period of six months ending on 30 September 2016. The paper extracts the key headlines, and the full report is attached as an appendix.

Quality impact:

N/A

Financial impact:

No direct financial impact.

Risk impact:

N/A

Recommendation(s) to the Committee:

The Committee is asked to note the paper.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources, and effective governance.

Author	Responsible executive director	Date submitted
NHS Improvement	Dr Tracey Batten, chief executive	21 November 2016

NHSI 2016/17 QUARTER 2 FINANCES AND PERFORMANCE

KEY HEADLINES

- The Q2 net deficit for the sector is £648m, compared to £461m at Q1 (see figure 1). This is £968m better than at Q2 2015/16 and £18m worse than at the same time of 2014/15.
- Including the £1.8 billion of sustainability and transformation funding (STF), the sector has forecast to end the year with a deficit of £669m, £89m worse than plan.
- Against forecast, the aggregate deficit at month six is marginally over plan by £22 million. The sector was £5m ahead of plan at Q1. 71 providers reported an adverse variance against plan at Q2. The overall net adverse variance was largely driven by:
    - Cost Improvement Plans (CIPs) that were £92m under forecast delivery
    - Bed days lost due to delayed transfers of care (DTOC) rising by 35% compared to Q2 last year
    - Agency costs exceeding plan by almost 16%
    - Adverse variance of £195 million for non-pay items. In particular, costs of drugs and clinical supplies significantly exceeded plan.
- 142 (60%) of 237 providers are reporting a deficit, compared to 153 (65%) at Q1 (figure 2) and 182 at Q2 in 2015/16.
    - Overall, 118 providers are forecasting a year-end deficit
    - At Q2, 227 providers have accepted their 2016/17 control totals, giving them access to STF. The funding has been included by 221 out of 227 trusts in their forecast outturn.

Other key finance data at Q2

- The amount of STF funding awarded to providers over the first 6 months of 2016/17 was £703m. This has been allocated across 211 trusts. There was a total of £197 million unallocated STF that trusts have not received due to missing of control total and performance targets. However, this has been added to the total aggregate deficit position, with a total positive impact of £900m.
- Capital expenditure (capex) was £1.1bn at month 6, £650m below plan. The current forecast capex for year end is £3.7bn - this is in excess of the nationally available capital departmental expenditure limit of £2.7bn.
- Total CIP delivery was £1.2 billion. This includes £247 million from income generation schemes. This CIP delivery has reduced total year-to-date expenditure by 2.9%. Compared to the same period last year, providers delivered an extra £73 million of cost savings. However there has been year-to-date CIP slippage, and providers project a CIP outturn of £3.2 billion at year end, £122m below plan. Despite this, this forecast is £346m above what was achieved in 2015/16.
- Agency spends equalled £1.5 billion, £312m less than the same period last year. Providers are currently forecasting a £900 million full-year reduction in agency spend compared to last year's actual spend of £3.6 bn.
- Financial sanctions equalled £55m, after factoring in reinvested fines. STF rules mean that providers do not face penalties if they accept control totals. This change has resulted in providers forecasting a drop in the financial sanctions for the year from net £308 million last year to £89 million this year (including reinvested fines). However, MRET and readmissions sanctions are forecast to rise against last year's end position.
- EBITDA for foundation trusts and NHS trusts was 2.6%, compared to a planned 3.1%.

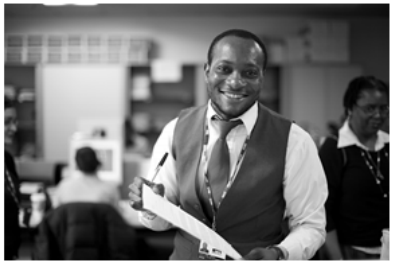
Key non-financial information

- In the explanatory note, NHSI state they are "considering introducing special measures for A&E performance for a small number of trusts to provide more intensive improvement support.
- 5.44m patients attended A&E department, 5.5% higher than the same quarter last year. NHS providers managed to treat, admit and discharge 89.7% of A&E patients within four hours, but 107,582 patients waited more than four hours for a bed, 70.1% more than a year ago.
- The waiting list reached the highest recorded level of 3.51 million. Referral-to-treatment (RTT) performance was at 90% for the quarter. GP referrals increased by 3.8% compared to the same period last year.
- Ambulance services continue to fail the Red 1, Red 2 and 19 minutes response-time targets with performance of 68.60%, 62.07% and 90.49% respectively.

NHS Improvement

Quarterly performance of the provider sector as at 30 September 2016





Contents

1.0 Operational performance

- 1.1 Operational performance overview
- 1.2 Accident & emergency (A&E)
- 1.3 Diagnostic waiting times
- 1.4 Elective waiting times
- 1.5 Cancer waiting times
- 1.6 Ambulance response times
- 1.7 Infection control

2.0 Financial performance

- 2.1 Financial performance overview
- 2.2 Income & expenditure
- 2.3 Pay and agency costs
- 2.4 Non-pay cost pressures
- 2.5 Cost improvement programmes
- 2.6 Capital expenditure
- 2.7 Forecast outturn

3.0 Financial performance by providers

4.0 Operational performance by providers

5.0 Agency staff

6.0 End notes and glossary

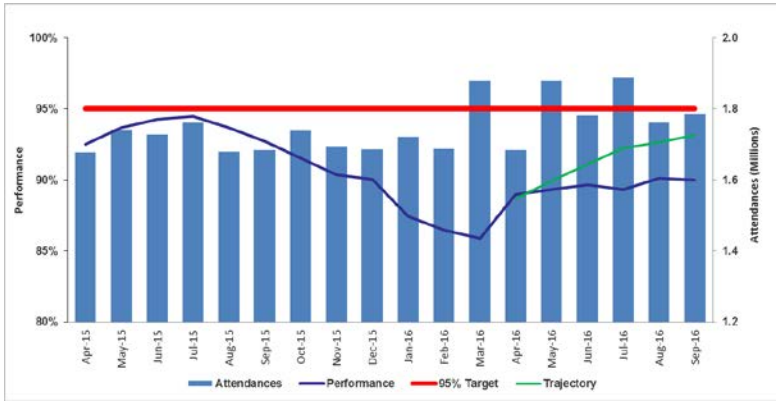
1.0 Operational performance

1.1 Operational performance overview

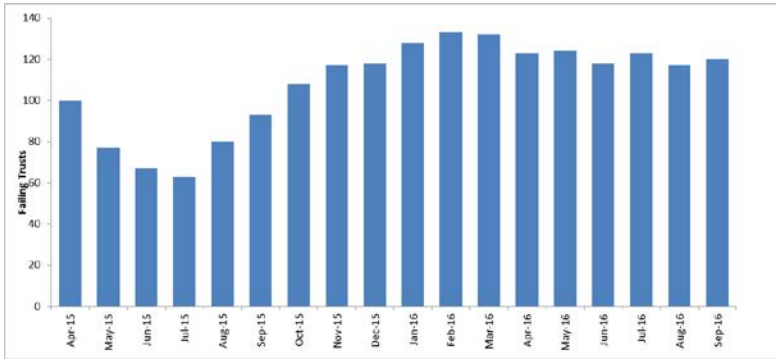
Metrics	Target	NHS Improvement	NHS England
Accident & emergency : July – September 2016			
A&E attendances	-	5,435,662	5,961,443
Performance – All A&E types (%)	*95%*	89.74%	90.62%
Performance – Acute trusts only (%)	*95%*	88.85%	88.85%
Type 1 performance (%)	*95%*	85.90%	85.90%
Diagnostics: at 30 September 2016			
Number of diagnostic tests waiting 6 weeks+ (%) – September 2016	*1%*	1.50%	1.48%
Referral to treatment (RTT) : at 30 September 2016			
18 weeks incomplete (%)	*92%*	90.28%	90.60%
52-week waits (number)	-	1,165	1,181
Cancer: July – September 2016			
2-week GP referral to 1st outpatient, cancer (%)	*93%*	94.15%	94.15%
2-week referral to 1st outpatient - breast symptoms (%)	*93%*	93.33%	93.35%
31-day wait from diagnosis to first treatment (%)	*96%*	97.58%	97.56%
62-day urgent GP referral to treatment for all cancers (%)	*85%*	82.27%	82.32%
62-day referral from screening services	*90%*	92.40%	92.35%
Ambulance: July – September 2016			
Red 1 Calls (%)	*75%*	68.60%	68.60%
Red 2 Calls (%)	*75%*	62.07%	62.07%
Category A Call - ambulance arrived within 19 mins (%)	*95%*	90.49%	90.49%
Infection control: July – September 2016			
C. Difficile (Total cases)	-	1,256	1,256

1.2 Accident & emergency

Percentage of A&E all type patients seen within 4 hours



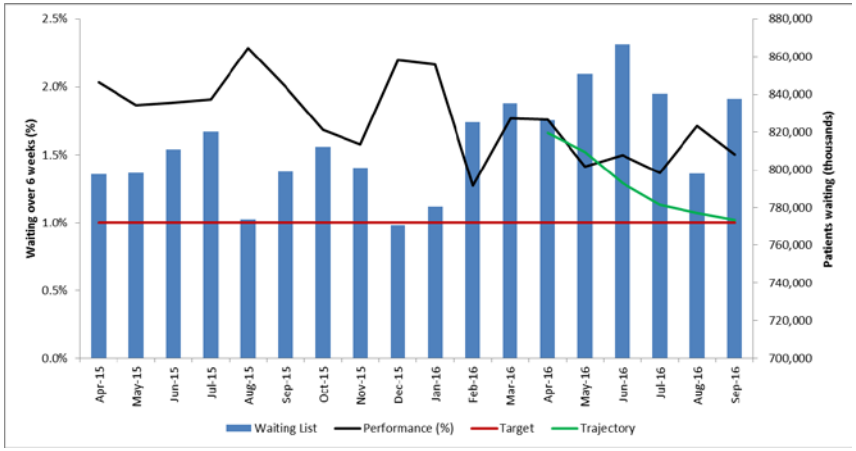
Number of Trusts failing the 4 hour A&E target by month



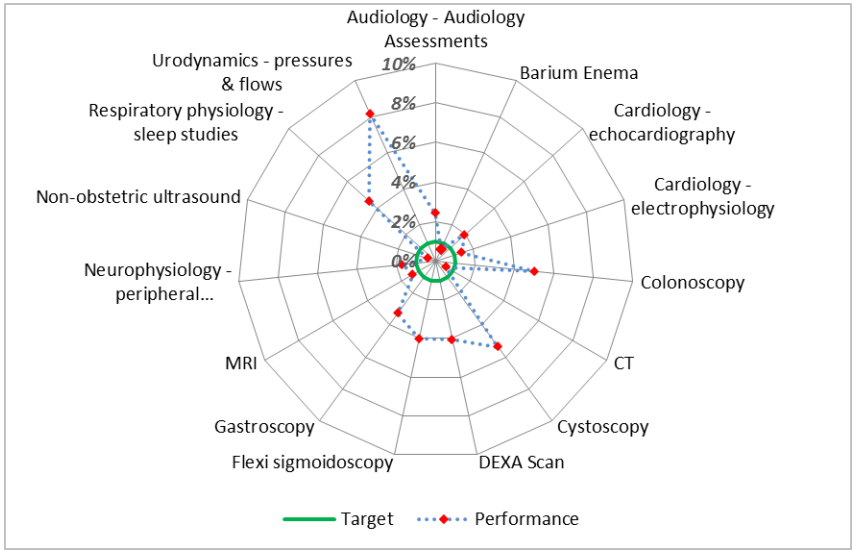
- NHS providers continue to struggle to meet the national A&E target to treat, admit or discharge 95% of patients within four hours of arriving at an A&E department. After recording the lowest level of performance of 86.58% in Q4 2015/16, performance began to recover in Q1 2016/17 at 89.31%. Performance continued to improve slightly in Q2 2016/17 with 89.74% of patients waiting less that four hours in A&E during the quarter (NHS England performance was 90.62%). Despite the slight improvement, this quarter's performance was well below the level achieved in the same quarter last year (93.63%) and the 95% target. A&E performance in September also remained below the aggregate STF improvement trajectory of 93.13% for month six for the provider sector.
- Increased demand coupled with bed capacity constraints compounded the pressure on A&E departments. In Q2 2016/17, there were c.5.44m attendances at NHS A&E departments, an increase of 5.5% (like-for-like) compared to the same quarter last year and 1.7% compared to Q1 2016/17. Although NHS providers were faced with increased demand, they were able to see 2.2% more patients within four hours compared to the last quarter.
- Rising numbers of patients requiring emergency admissions added to the operational pressure on A&E departments. This quarter, the number of patients attending a major (type 1) A&E department and requiring admitted care reached c.1.04m, a rise of 4.1% compared to the same quarter last year.
- Bed capacity constraints due to high occupancy rates and delayed transfers of care have resulted in many patients requiring admission waiting significantly longer in A&E departments for a bed. In Q2 2016/17, 107,582 patients waited more than four hours for a bed, 70.1% more than a year ago. There were also 385,634 bed days lost due to delayed transfers of care in acute hospitals, an increase of 34.8% from a year ago.
- The national Emergency Care Improvement Programme (ECIP) is recruiting and training the additional staff it requires to deliver intensive support to 40 local health systems. With winter months approaching, the work is now focused on helping providers to improve their operational resilience. ECIP is now integrating its work programmes with NHS Improvement regional offices and now offers support relating to ambulance handover, health and social care integration and delivery of the national A&E plan.

1.3 Diagnostic waiting times

Percentage of diagnostic patients waiting over 6 weeks



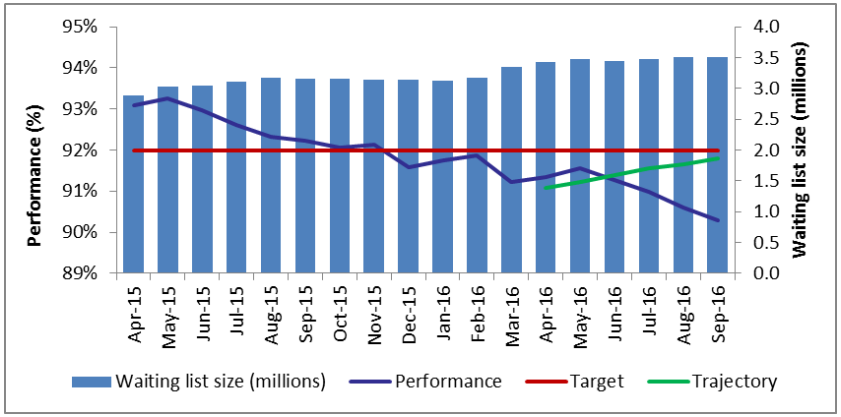
Diagnostic performance by procedures – September 2016



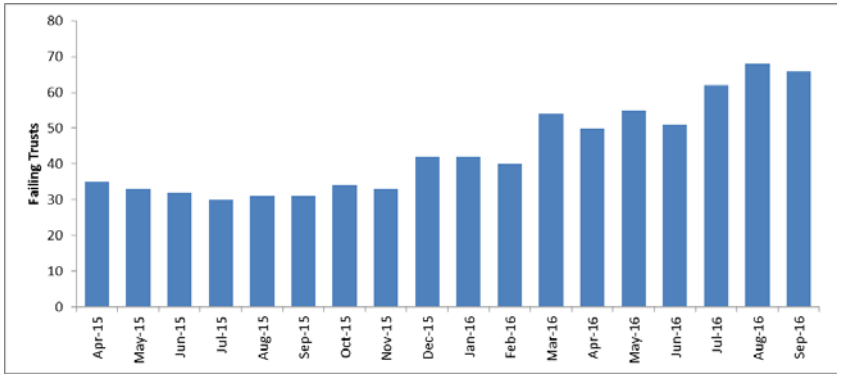
- Diagnostic waiting times are a key part in the delivery of the referral to treatment (RTT) target as the majority of patients being referred for hospital treatment will require a diagnostic test. The national waiting time target for diagnostics states that less than 1% of patients should wait six weeks or more for a test.
- At the end of Q2 2016/17, 837,616 patients were waiting for a diagnostic test, a decrease of 3.3% from the last quarter. However, compared to the same time last year, the waiting list has increased by 5.3% (like-for-like). Despite the increase in the waiting list, fewer patients were waiting longer than six weeks. Performance of 1.50% at Q2 2016/17 (NHS England performance was 1.48%) was a significant improvement compared to a performance of 2.00% at Q2 last year. Although performance improved, it remains below the aggregate STF improvement trajectory of 1.02% for month six for the provider sector.
- Providers in aggregate failed to achieve the waiting time standard for 12 of the 15 key diagnostic tests, one more than in the same period last year.
- The overall improvement in diagnostics performance has been driven by a reduction in waiting times for endoscopy tests which contribute over 10% of the diagnostics waiting list. A national programme team has been working with providers to address endoscopy performance and capacity issues since the start of last year. In September 2016, 4.24% of patients were waiting over six weeks for an endoscopy test compared to 7.43% a year ago. To help increase capacity further, NHS Improvement is working with Health Education England to launch the next stage of its programme to train 200 additional Non-Medical Endoscopists (NME) by 2018.
- In contrast, non-obstetric ultrasound was the best performing test despite having the largest waiting list (35.5% of the total diagnostics waiting list), with only 0.41% of patients waiting over six weeks at the end of the quarter.

1.4 Elective waiting times

RTT 18 week performance and size of waiting list by month



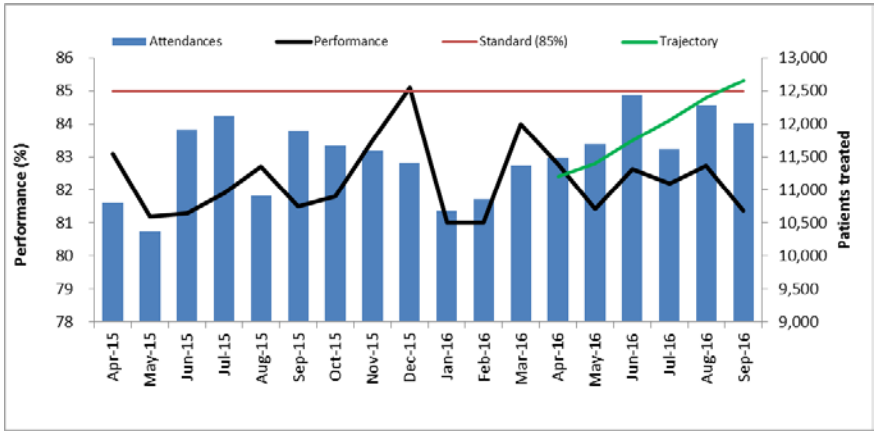
Number of trusts failing RTT 18 week incomplete target by month



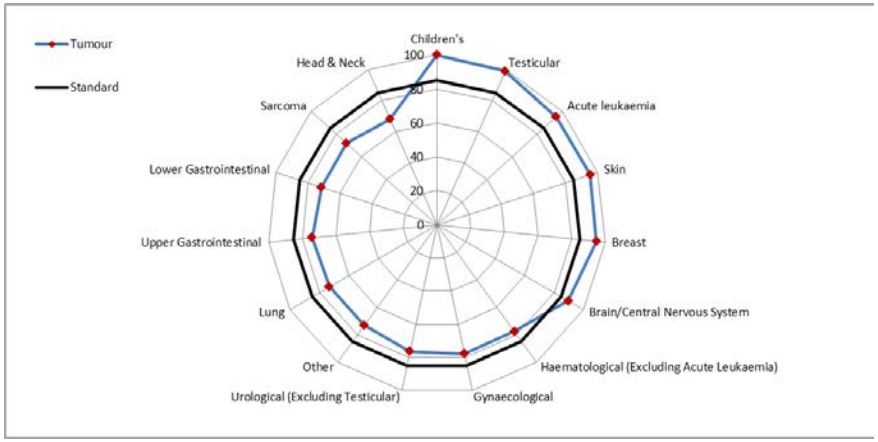
- NHS providers continue to fail to achieve the national RTT incomplete standard target of 92%. Performance this quarter was 90.28% (NHS England performance was 90.60%) which represents the lowest performance since providers started to underperform against the target in December 2015. The performance was also well below the aggregate STF improvement trajectory of 91.79% for NHS providers.
- Sustained high demand for emergency inpatient care coupled with junior doctor strikes this year has resulted in many providers struggling to deliver their planned activity due to elective capacity either being displaced or cancelled. In the meantime, GP referrals increased by 3.8% compared to the same period last year. As a result, the elective waiting list reached a record level of 3.51 million at the end of Q2 2016/17, an 11.0% increase compared to a year ago (like-for-like and excluding providers which have re-commenced reporting this year).
- In line with the drop in performance and the increase in the overall waiting list, the number of patients waiting longer than 52 weeks for treatment also increased. In September 2016, 1,165 patients were waiting over a year for treatment compared to 936 in June 2016. Nine providers did not report incomplete RTT performance in September 2016, so the actual number of over 52-week waiters could be significantly higher.
- The Intensive Support Team is continuing to support the most challenged providers to improve performance by better aligning demand and capacity. We are also supporting a national programme to improve outpatient performance through agreeing pilot sites to use software to improve patient flow and using digital channels to reduce demand and improve access to services.

1.5 Cancer waiting times

62-day (urgent GP referral) wait for first treatment by month



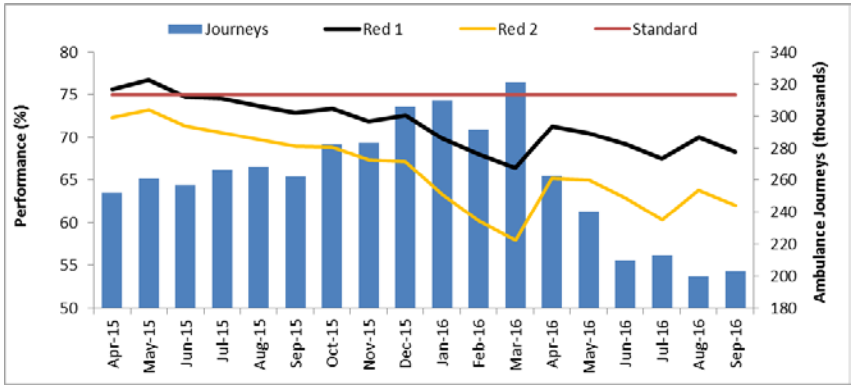
62-day (urgent GP referral) wait for first treatment by specialty – Q2 2016/17



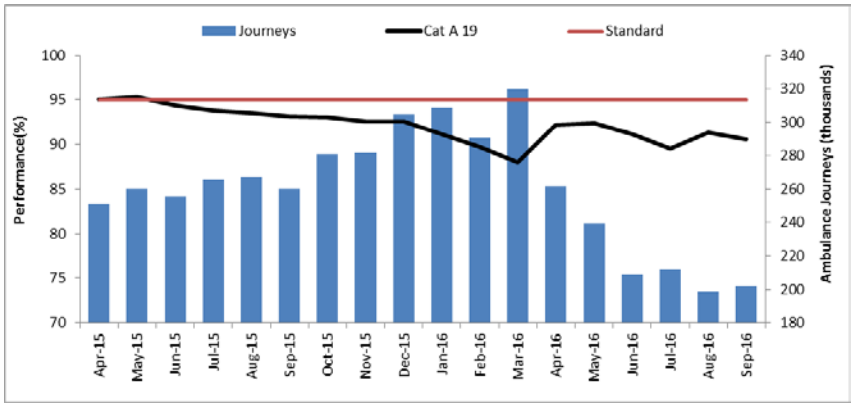
- All the cancer waiting-time standards were achieved in Q2 2016/17 except for the 62 day (urgent GP referral) waiting time target for first treatment, which has not been delivered since Q3 2013/14.
- In response to increasing demand, more patients began treatment this year. 36,637 patients began cancer treatment in Q2 2016/17, 3.1% more than in the same quarter last year.
- Despite the increase in activity, NHS providers failed to achieve the national target of 85% with a performance of 82.3% in Q2 2016/17 (NHS England performance was 82.8%). Although this was an improvement on the performance achieved in the same quarter last year (82.1%), it was still well below the aggregate STF improvement trajectory of 85.3% for month 6 for the provider sector.
- The specialties that contributed most to the underperformance in Q2 2016/17 were Urological (excluding testicular), Lower Gastrointestinal and Lung. These specialities accounted for only 40% of activity, but contributed to more than half of the reported breaches (57%).
- NHS Improvement has worked with partners to improve cancer performance by reducing diagnostic delays. We are also continuing to work with NHS England to introduce the 28 days faster diagnosis standard for cancer patients. The standard is now being piloted at test sites in preparation for national roll-out.

1.6 Ambulance response times

Category A Red 1 and Red 2 performance and volume of response



Category A19 performance and volume of responses



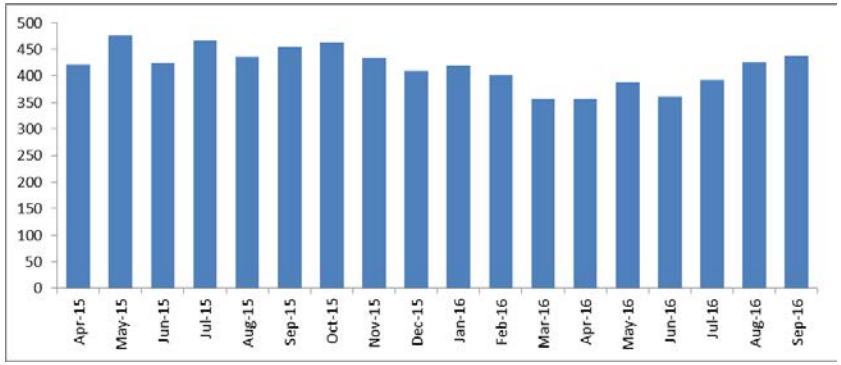
- The national standard states that 75% of calls, presenting conditions which may be immediately life-threatening (Category A Red 1), or life-threatening but less time-critical (Category A Red 2), should receive an emergency response within eight minutes, and 95% of all Category A responses requiring an ambulance, should be reached within 19 minutes.
- Ambulance services continue to fail the Red 1, Red 2 and 19 minutes response-time targets with performance of 68.60%, 62.07% and 90.49% respectively. In Q2 2016/17, none of the eight ambulance services* that submitted complete data achieved any of the three standards.
- Ambulance services saw an increase in time-critical and life-threatening calls in Q2 2016/17. Ambulance services responded to 29,013 Red 1 calls in the quarter, an increase of 9.9% compared to the same quarter last year. The number of Red 2 responses increased by 14.1% compared to the same period last year.**
- Due to 'dispatch-on-disposition' pilots at a number of ambulance services, a direct like-for-like performance comparison between Q2 2015/16 and Q2 2016/17 for the Red 2 and Category A standards cannot be made. The pilots allow call handlers extra time to triage Red 2 calls, and result in different clock start times.
- In February 2015, London Ambulance Service and South Western Ambulance Service NHS Foundation Trust implemented the pilot, and in October 2015 it was introduced at four more ambulance trusts.

** There are 11 ambulance services including 10 ambulance trusts as well as Isle of Wight NHS Trust. Three trusts (South Western Ambulance Service and Yorkshire Ambulance Service from April 2016, and West Midlands Ambulance Service from June 2016) have been piloting new call categorisations, and, therefore, have not been submitting data for Red 1, Red 2 and Cat A 19 minute responses.*

*** Comparisons exclude South Western Ambulance Service, Yorkshire Ambulance Service and West Midlands Ambulance Service activity in Q2 2015/16 and Q2 2016/17.*

1.7 Infection control

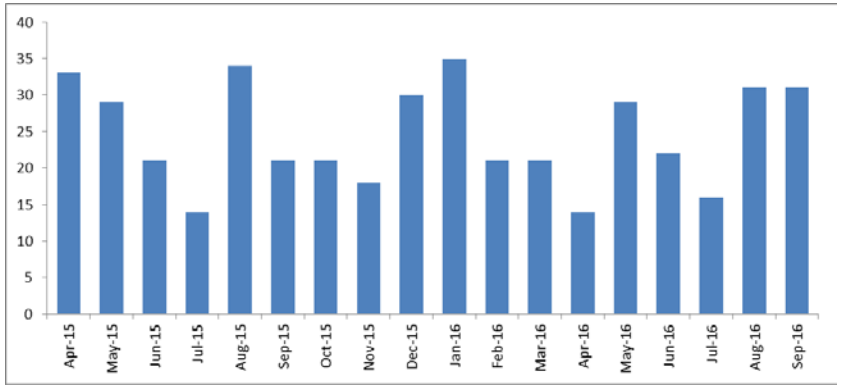
Number of Clostridium Difficile cases



Clostridium Difficile (C. Diff)

- The number of trust apportioned C. Diff cases reported in Q2 2016/17 was 1,256 compared to 1,356 in the corresponding quarter last year. This was a decrease of 7.4% from the same quarter last year.
- Between April and September 2016, there were 2,361 C. Diff cases reported, a reduction of 11.8% (316 cases) from the same period last year.

Number of Meticillin-resistant Staphylococcus Aureus cases reported



Meticillin-resistant Staphylococcus Aureus (MRSA)

- 78 MRSA cases were reported in Q2 2016/17 compared to 69 in the same quarter last year.
- Between April and September 2016, there were 143 MRSA cases reported, a reduction of 5.9% (9 cases) from the same period last year.

2.0 Financial performance

2.1 Financial performance overview

6 months ended 30 September 2016 by sector	Number of providers	Year to Date - Month 6 2016/17				Forecast Outturn - 2016/17			
		Plan	Actual	Variance	Deficit providers	Plan	Forecast	Variance	Deficit providers
	No.	£m	£m	£m	No.	£m	£m	£m	No.
Acute	137	(758)	(881)	(123)	99	(893)	(1,131)	(238)	83
Ambulance	10	(11)	(17)	(6)	6	(7)	(24)	(17)	6
Community	18	1	(2)	(3)	6	25	23	(2)	4
Mental Health	56	7	10	3	23	61	48	(13)	18
Specialist	17	(2)	3	5	8	17	17	-	7
Total Surplus / (deficit) - control total [1]	**238**	**(763)**	**(887)**	**(124)**	**142**	**(797)**	**(1,067)**	**(270)**	**118**
Technical Adjustments - FT and part year NHS trusts [2]		21	42	21		32	71	39	
Reported Financial Position surplus / (deficit)		**(742)**	**(845)**	**(103)**		**(765)**	**(996)**	**(231)**	
Unallocated sustainability and transformation fund (STF)		58	58	-		115	115	-	
STF allocated to providers not accepting the control total		35	35	-		70	70	-	
STF allocated to providers not achieved		23	104	81		-	142	142	
Reported Financial Position surplus / (deficit) after STF		**(626)**	**(648)**	**(22)**		**(580)**	**(669)**	**(89)**	

6 months ended 30 September 2016 by region	Number of Providers	Year to Date - Month 6 2016/17				Forecast Outturn - 2016/17			
		Plan	Actual	Variance	Deficit providers	Plan	Forecast	Variance	Deficit providers
	No.	£m	£m	£m	No.	£m	£m	£m	No.
London	36	(190)	(271)	(81)	22	(226)	(297)	(71)	19
Midlands and East	73	(357)	(371)	(14)	45	(520)	(555)	(35)	38
North	74	(110)	(109)	1	42	(46)	(70)	(24)	34
South	55	(106)	(136)	(30)	33	(5)	(145)	(140)	27
Total Surplus / (deficit) - control total [1]	**238**	**(763)**	**(887)**	**(124)**	**142**	**(797)**	**(1,067)**	**(270)**	**118**
Technical Adjustments - FT and part year NHS trusts [2]		21	42	21		32	71	39	
Reported Financial Position surplus / (deficit)		**(742)**	**(845)**	**(103)**		**(765)**	**(996)**	**(231)**	
Unallocated sustainability and transformation fund (STF)		58	58	-		115	115	-	
STF allocated to providers not accepting the control total		35	35	-		70	70	-	
STF allocated to providers not achieved		23	104	81		-	142	142	
Reported Financial Position surplus / (deficit) after STF		**(626)**	**(648)**	**(22)**		**(580)**	**(669)**	**(89)**	

1. *Surplus/(deficit) comparable to control totals are calculated as surplus/(deficit) before impairments, transfers, donated asset income, and donated asset depreciation for all trusts. For non-FTs, IFRIC 12 adjustments are also deducted. For most FTs gains/(losses) on asset disposals are excluded (unless previously agreed)*
2. *For FTs, the sector reported surplus/(deficit) includes donated asset income, donated asset depreciation t and gains/(losses) on asset disposals (unless previously agreed), as these items have been excluded from the control total an adjustment is needed to add the figures back to provide the reported sector surplus/(deficit). This also includes the NHS trust IFRIC12 adjustment for those trusts gaining FT status in year (NHS trust period only).*

2.2 Income & expenditure

6 months ended 30 September 2016	Year to Date - Month 6 2016/17			
	Plan	Actual	Variance	
	£m	£m	£m	%
Operating Revenue for EBITDA	39,334	39,433	99	0.3%
Pay	(25,052)	(25,129)	(77)	0.3%
Other Operating Expenses	(13,073)	(13,267)	(194)	1.5%
EBITDA	**1,209**	**1,037**	**(172)**	**(14.2%)**
All other Expenses not included in EBITDA	(1,972)	(1,924)	48	(2.4%)
Control Total Basis Surplus / (Deficit)	**(763)**	**(887)**	**(124)**	**16.3%**
Technical Adjustments - FT and part year NHS trusts	21	42	21	100.0%
Provider Reported Financial Position surplus / (deficit)	**(742)**	**(845)**	**(103)**	**13.9%**
Unallocated sustainability and transformation fund (STF)	116	197	81	69.8%
Sector Reported Financial Position surplus / (deficit)	**(626)**	**(648)**	**(22)**	**3.5%**
EBITDA %	3.1%	2.6%		
Control Total Basis Surplus / (Deficit)	(1.9%)	(2.2%)		

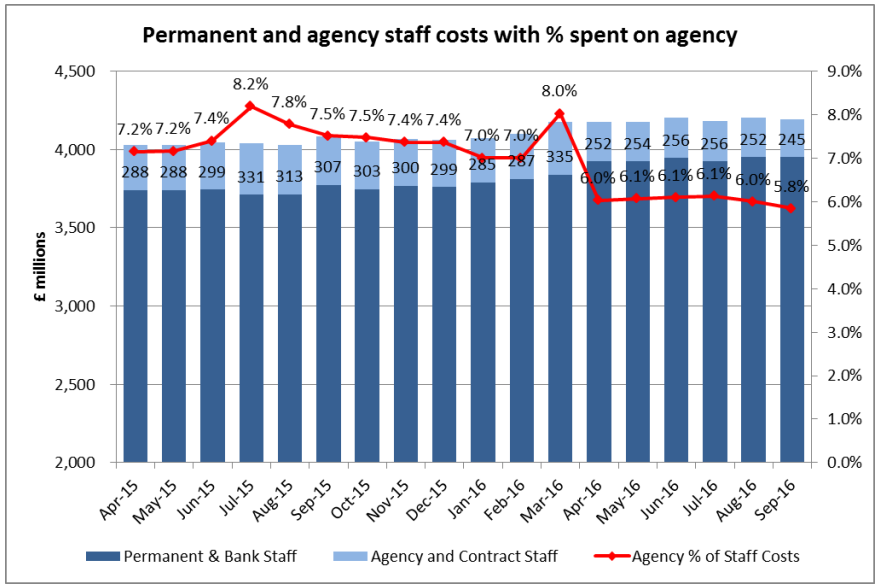
6 months ended 30 September 2016	Year to Date - Month 6 2016/17				
	Acute	Ambulance	Community	Mental Health	Specialist
	£m	£m	£m	£m	£m
Operating Revenue for EBITDA	29,533	1,126	1,459	5,712	1,603
Pay	(18,219)	(795)	(978)	(4,223)	(913)
Other Operating Expenses	(10,688)	(296)	(446)	(1,212)	(626)
EBITDA	**626**	**35**	**35**	**277**	**64**
All other Expenses not included in EBITDA	(1,507)	(52)	(37)	(267)	(61)
Control Total Basis Surplus / (Deficit)[1]	**(881)**	**(17)**	**(2)**	**10**	**3**
EBITDA %	2.1%	3.1%	2.4%	4.8%	4.0%
Control Total Basis Surplus / (Deficit)	(3.0%)	(1.5%)	(0.1%)	0.2%	0.2%

- The provider sector's year-to-date financial performance has deteriorated from a position of £5m ahead of plan at Q1 to an underperformance of £22 million against plan at Q2 2016/17. Despite the deterioration, the monthly run rate showed improvement when compared to the same period last year, and the reported year-to-date sector deficit at Q2 of £648 million indicated a £968 million improvement on last year's Q2 position.
- The sector's year-to-date position included a £887 million combined deficit at provider level on control total basis, £42 million technical adjustment and £197 million unallocated Sustainability and Transformation fund (STF).
- 'Financial control totals' were introduced in 2016/17 to set out the minimum level of financial performance for both the sector and individual trusts. Since our report at Q1, 13 more providers have signed up to their control totals, taking the number of providers accepting their individual control totals to 227 at Q2.
- In total, 71 providers reported an adverse variance against plans at Q2. The overall adverse variance was largely driven by increased costs as a result of higher activity. Despite efforts made by providers to reduce their agency staff costs, year-to-date agency costs continued to exceed plan by almost 16%. In addition, higher than planned demand also led to increased spending on drugs and clinical supplies. This has in turn affected many providers' ability to deliver their planned cost savings.
- To support providers returning to a more sustainable financial footing, a £1.8 billion STF was introduced in 2016/17. Providers are eligible for accessing STF if they accept and deliver their individual control totals and meet an agreed performance trajectory for certain waiting-time standards. At Q2 2016/17, 211 trusts have either fully or partially met their funding criteria, resulting in £703 million STF being included in the provider sector's year-to-date position on a control total basis. Adding back the £197 million unallocated STF, a total of £900 million of STF has been reflected in the year-to-end sector position.

2.3 Pay and agency costs

6 months ended 30 September 2016	Year to Date - Month 6 2016/17			
	Plan	Actual	Variance	
	£m	£m	£m	%
Permanent & bank staff	23,743	23,615	(128)	(0.5%)
Agency & Contract staff	1,309	1,514	205	15.7%
Total	**25,052**	**25,129**	**77**	**0.3%**
Agency costs as a % of total pay costs	5.2%	6.0%		

6 months ended 30 September 2016	Forecast Outturn - 2016/17			
	Plan	Forecast	Variance	
	£m	£m	£m	%
Permenant & bank staff	47,442	47,382	(60)	(0.1%)
Agency & Contract staff	2,366	2,668	302	12.8%
Total	**49,808**	**50,050**	**242**	**0.5%**
Agency costs as a % of total pay costs	4.8%	5.3%		



- Year-to-date agency expenditure of £1.5 billion was reported at Q2 2016/17, which was £312million less than the same period last year. This contrasted with a trajectory which saw annual agency costs grow at a rate of 25% in the past three years prior to the introduction of agency controls. This level of increase has put a significant strain on providers' finances over the period.
- 71% of trusts have reduced their agency expenditure since the introduction of the agency rules in November 2015. Providers are currently forecasting a £900 million full-year reduction in agency expenditure compared to last year's actual spend of £3.6 billion. However, the forecast remains £200 million above the agency expenditure ceilings. Therefore, some trusts need to deliver further savings to bring spend in line with their individual agency expenditure ceilings.
- NHS Improvement wrote to all providers in early October to outline a set of next steps and immediate actions for providers to take to reduce over-reliance on agency staff. The letter also outlined specific actions for those trusts missing their agency expenditure ceiling.
- In addition, tackling excessive pay bill growth remain as a top priority for providers. Providers had planned for annual pay costs to grow by 2.3% this year. However, the forecast at Q2 suggests that annual growth could exceed 2.6%. Although this is partly related to pay inflation, review of pay growth by NHS Improvement at the start of the year showed that a number of providers' pay growth was in excess of inflation and pension effects which was highlighted in the financial reset document 'Strengthening Financial Performance & Accountability in 2016/17'. In early October, NHS Improvement also wrote to all providers asking trust boards to undertake a full review of the pay-related investment in the past two years. NHS Improvement regional teams are now working with trusts to review the outcome of this work.

2.4 Non-pay cost pressures

6 months ended 30 September 2016	Year to date - Month 6 2016/17 Plan £m	Actual £m	Variance £m	Variance %
Employee expenses	**(25,052)**	**(25,129)**	**(77)**	**0.3%**
Drugs	(3,357)	(3,419)	(62)	1.8%
Supplies and services - clinical (excluding drugs)	(3,073)	(3,135)	(62)	2.0%
Supplies and services – general	(918)	(924)	(6)	0.7%
Purchase of healthcare from non-NHS bodies	(520)	(544)	(24)	4.6%
Consultancy costs	(110)	(119)	(9)	8.2%
PFI/LIFT operating expenses	(461)	(446)	15	(3.3%)
Clinical negligence	(784)	(795)	(11)	1.4%
Premises	(1,437)	(1,407)	30	(2.1%)
All other operating non-pay	(2,413)	(2,479)	(66)	2.7%
Non-pay expense included in EBITDA	**(13,073)**	**(13,268)**	**(195)**	**1.5%**
Operating expenditure for EBITDA	**(38,125)**	**(38,397)**	**(272)**	**0.7%**

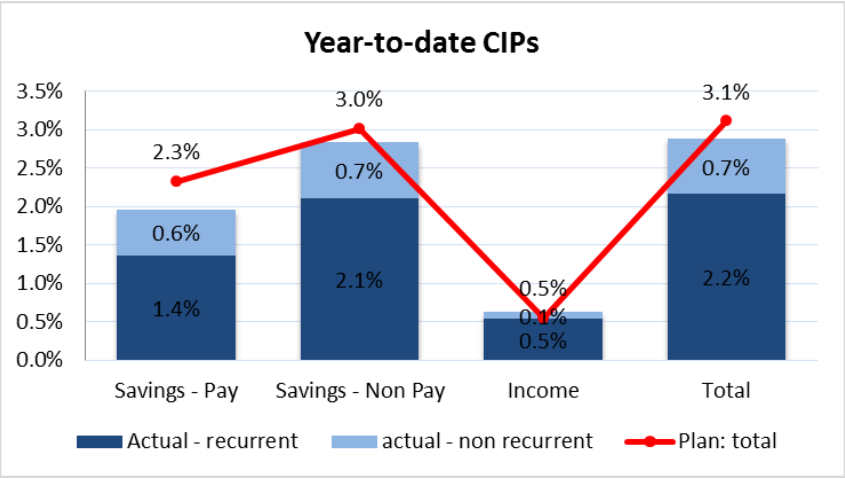
6 months ended 30 September 2016	Month 6 2016/17 £m	Forecast Outturn £m
Financial Sanctions (Fines)	77	126
Sanctions reinvested	(22)	(37)
Sub-total: Financial Sanctions	**55**	**89**
Marginal Rate Emergency Tariff (MRET)	129	262
MRET reinvested	(8)	(27)
Sub-total: MRET	**121**	**235**
Readmissions	135	269
Readmissions reinvested	(28)	(62)
Sub-total: Readmissions	**107**	**207**
Delayed transfers of care (DToC) - expenditure incurred on blocked capacity	88	185
DToC - reimbursement from Local Authorities	(2)	(5)
Sub-total: Delayed Transfers of Care	**86**	**180**
Waiting list initiative work	**88**	**153**
Outsourcing of work to other providers	**183**	**349**

- Year-to-date cost weighted activity has grown by 2.9% compared to the same period last year, this has put many providers under significant pressure. The volume factor coupled with rising costs has led to an adverse variance of £195 million being reported for non-pay items at Q2. In particular, costs of drugs and clinical supplies have significantly exceeded plan.
- The record level of demand has resulted in capacity constraint, hence, providers have reported increased levels of work being done either through waiting list initiative sessions or outsourcing to other providers. So far, providers have spent £88 million on waiting list initiative and £183 million on outsourcing in the first six months of the year. Providers forecast the annual costs associated with waiting list initiative will grow from £143 million in 2015/16 to £153 million this year, and outsourcing will rise from £241 million to £349 million.
- Sustained high demand and capacity constraints have also left many providers failing to meet the national standards. In previous years, underperformance against national standards often resulted in financial sanctions being levied on providers. However, the introduction of STF has meant that providers will not face these penalties if they have accepted their control totals and meet their agreed performance trajectories for access standards this year. This change has resulted in providers in aggregate forecasting a drop in the financial sanctions for the year from £308 million last year to £89 million this year.
- Delayed transfers of care (DToCs) has also continue to have a detrimental impact on many providers both operationally and financially. The bed days lost due to DToCs have risen by 35% at Q2 compared to last year. Lord Carter, in his review, regarded DToCs as a ‘major problem’ for the NHS and called for action to be taken to tackle this issue. Providers forecast that the direct cost associated with DToCs could reach £180 million for 2016/17, £35 million more than 2015/16. However, full costs associated with DToCs are likely to be much higher than what providers have reported.

2.5 Cost improvement programmes

6 months ended 30 September 2016	Year to date - Month 6 2016/17		
	Plan	Actual	Variance
	£m	£m	£m
Recurrent	1,177	894	(283)
Non-recurrent	112	303	191
Total cost improvement programmes	**1,289**	**1,197**	**(92)**
CIPs as a % of spend	3.1%	2.9%	

6 months ended 30 September 2016	Forecast Outturn - 2016/17		
	Plan	Forecast	Variance
	£m	£m	£m
Recurrent	3,089	2,689	(400)
Non Recurrent	272	550	278
Total Cost Improvement Programmes	**3,361**	**3,239**	**(122)**
CIPs as a % of Spend	4.0%	3.9%	



- During the first half of this financial year, providers delivered £1.2 billion of savings through cost improvement programmes (CIPs), including £247 million from income generation schemes. CIPs reduced total year-to-date expenditure by 2.9%.
- Compared to the same period last year, providers delivered an extra £73 million of cost savings. However, the year-to-date CIPs achieved was still £92 million short of plan. This was largely due to sustained demand pressures and recruitment difficulties, as providers failed to deliver both their year-to-date planned pay and non-pay savings by a shortfall of £95 million and £25 million respectively. However, providers have outperformed on their planned income generation schemes by delivering an extra £29 million to offset the combined shortfalls in pay and non pay savings.
- 75% (£894 million) of the savings achieved year-to-date were through recurrent schemes, which was below the planned level of 91% (or £1.17 billion). Providers have managed to compensate for this by delivering £190 million extra savings through non-recurrent CIPs during the period.
- The year-to-date CIP slippage has led providers to project a CIP outturn of £3.2 billion at the year end, £122 million below plan. Despite this, the forecast is over £346 million more than that achieved in 2015/16.
- Given the sector's financial challenges, providers have been asked to increase their focus on efficiency this year. The efficiency team within NHS Improvement has been working closely with the sector to implement recommendations from Lord Carter's review. In July, NHS Improvement asked all providers to work with their STP leaders to produce a summary of opportunities for consolidating back office and pathology services. These actions are aimed at delivering both in-year benefits as well as enhanced benefits for ongoing financial sustainability. We expect that, as the year progresses, these new measures will allow providers to further strengthen their financial grip and improve their financial standing for the future.

2.6. Capital expenditure

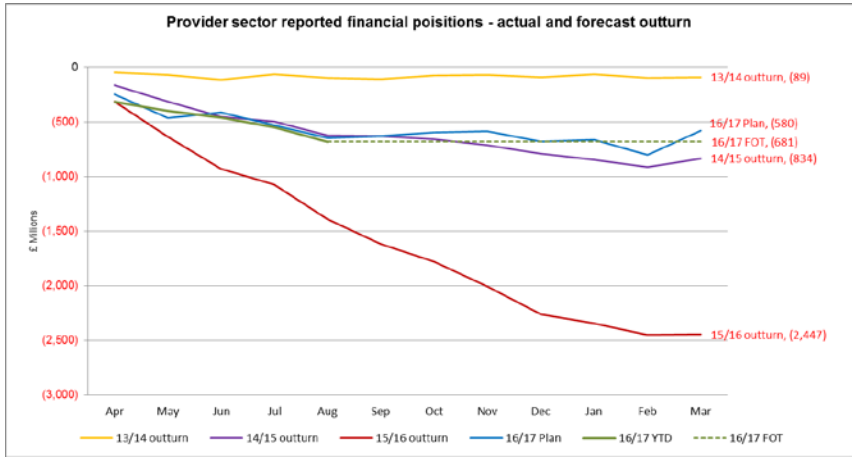
6 months ended 30 September 2016	Year to Date - Month 6 2016/17			
	Plan	Actual	Variance	
	£m	£m	£m	%
Acute	1,311	807	(504)	(38%)
Ambulance	50	30	(20)	(40%)
Community	35	18	(17)	(49%)
Mental Health	241	177	(64)	(27%)
Specialist	124	79	(45)	(36%)
Total Capital Dept Expenditure Limit (CDEL)	**1,761**	**1,111**	**(650)**	(37%)

6 months ended 30 September 2016	Forecast Outturn - 2016/17			
	Plan	Forecast	Variance	
	£m	£m	£m	%
Acute	3,102	2,802	(300)	(10%)
Ambulance	133	124	(9)	(7%)
Community	80	77	(3)	(4%)
Mental Health	480	468	(12)	(3%)
Specialist	276	256	(20)	(7%)
Total Capital Dept Expenditure Limit (CDEL)	**4,071**	**3,727**	**(344)**	(8%)

Provider Capital Summary	**Foundation Trusts**	**NHS Trusts**	**Total 16/17 Forecast**
Capital Dept Expenditure Limit (CDEL)	**£m**	**£m**	**£m**
Gross Capex	2,600	1,467	**4,067**
Disposals	(95)	(8)	**(103)**
Net	**2,505**	**1,459**	**3,964**
Minus PFI	(90)	(110)	**(200)**
Minus Grants and Donations	(143)	(46)	**(189)**
Plus PFI Residual Interest	64	76	**140**
Plus Financial Assets	12	0	**12**
CDEL	**2,348**	**1,379**	**3,727**

- Providers plan submissions included Capital Departmental Expenditure Limit CDEL expenditure of £4.071 billion in 2016/17.
- The forecast CDEL expenditure at Q2 is £3.727 billion, an underspend against plan of £344 million.
- Providers at Q2 had spent £1.111 billion on capital schemes, which was £650 million below plan.
- The level of capital expenditure incurred at Q2 represents 30% of the forecast outturn. This is not unusual given providers tend to spend a significant proportion of their capital budget in the later part of the year.
- Compared to 2015/16, the provider sector forecast to increase its aggregate capital expenditure (capex) from £2.969 billion to £3.727 billion.
- The current forecast capex of £3.727 billion for the year is in excess of the nationally available CDEL of £2.729 billion by £998 million.
- Foundation Trusts account for £2.348 billion (or 63%) of the 2016/17 forecast. NHS Trusts account for £1.379billion (or 37%) of the 2016/17 forecast.

2.7 Forecast outturn



Sustainability and Transformation fund 6 months ended 30 September 2016	Providers		Forecast Outturn - 2016/17	
	Total Number	Accepted Control Total	Number forecasting delivery (Full or Partial)	Forecast
	No	No	No	£m
Acute	137	132	131	1,342
Ambulance	10	8	6	8
Community	18	17	17	22
Mental Health	56	53	50	66
Specialist	17	17	17	35
Total in Provider Position	**238**	**227**	**221**	**1,473**
Balance held centrally				327
Total STF				**1,800**

- Providers have been making concerted efforts to improve their financial standings while responding to unrelenting demand. The monthly run rate compared to last year has seen a significant improvement.
- With the full support of £1.8 billion STF, the sector forecast to end the year with a deficit of £669 million which is £89 million worse than plan. Included within the sector's forecast outturn are providers' projected full-year deficit (on control total basis) of £1,067 million and £327 million of undrawn STF. The aggregate position of a deficit of £669 million also allows for a technical adjustment of £71 million.
- At Q2, 227 providers have accepted their control totals, giving them access to STF this year. The funding has been included by 221 out of 227 trusts in their forecast outturn either in full or on a partial basis.
- Overall, 118 providers are forecasting a year-end deficit. Among those, nine trusts are projecting a year-end deficit that is £10 million worse than that planned. To ensure that all providers meet their financial and performance commitment, NHS Improvement wrote to all providers in early October to outline a protocol for changes to in-year financial forecasts. This protocol has now been rolled out and will strengthen board governance and increase trusts' accountability for financial performance over time. In addition, our regional teams continue to support all providers that indicated downside risks in their outturn positions at Q2 to help them minimise these adverse risks. Eight trusts facing the biggest financial challenges are also being supported through our financial special measures programme.
- The operating environment remains challenging for providers for the remainder of the year as winter months approach. In order to secure financial delivery in 2016/17 and achieve long term financial sustainability, NHS Improvement continues to work in collaboration with the sector to meet the challenging performance trajectory. We expect that, as the year progresses, both existing and new measures will allow providers to further strengthen their financial grip and improve their financial standing for the future.

3.0 Financial performance by providers

3.1 Financial performance by providers – London

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
Barking, Havering and Redbridge University Hospitals NHS Trust	Yes	(4,299)	(4,372)	(73)	(11,900)	(11,900)	0	20,100	9,799	19,849
Barnet, Enfield and Haringey Mental Health NHS Trust	No	(6,444)	(6,393)	51	(12,590)	(12,590)	0	1,160	0	0
Barts Health NHS Trust	Yes	(40,328)	(40,290)	38	(82,700)	(82,700)	0	37,900	18,950	37,900
Camden And Islington NHS Foundation Trust	Yes	851	(225)	(1,076)	1,700	1,700	(0)	800	0	800
Central And North West London NHS Foundation Trust	Yes	(3,340)	(940)	2,400	(1,030)	(1,030)	(0)	2,770	1,385	2,770
Central London Community Healthcare NHS Trust	Yes	1,712	1,802	90	4,820	4,820	0	2,220	1,110	2,220
Chelsea And Westminster Hospital NHS Foundation Trust	Yes	3,284	3,671	386	4,417	4,417	(1)	14,800	7,400	14,800
Croydon Health Services NHS Trust	Yes	(19,527)	(16,838)	2,689	(25,482)	(25,482)	0	7,350	2,450	7,350
East London NHS Foundation Trust	Yes	5,713	952	(4,761)	11,774	2,931	(8,842)	2,480	1	0
Epsom and St Helier University Hospitals NHS Trust	Yes	(10,979)	(10,518)	461	(15,053)	(15,053)	0	11,300	5,415	11,300
Great Ormond Street Hospital for Children NHS Foundation Trust	Yes	1,361	2,135	774	2,241	2,242	1	2,400	1,200	2,400
Guy's And St Thomas' NHS Foundation Trust	Yes	(2,742)	(1,192)	1,550	6,516	5,448	(1,068)	19,200	8,360	15,320
Homerton University Hospital NHS Foundation Trust	Yes	1,388	2,192	804	1,402	1,699	297	6,100	3,051	6,100
Hounslow and Richmond Community Healthcare NHS Trust	Yes	364	400	36	1,600	1,600	0	600	300	600
Imperial College Healthcare NHS Trust	Yes	(14,795)	(14,332)	463	(16,862)	(16,862)	0	24,100	12,050	24,100
King's College Hospital NHS Foundation Trust	Yes	(26,372)	(60,577)	(34,204)	(1,600)	(1,601)	(1)	30,000	0	30,000
Kingston Hospital NHS Foundation Trust	Yes	(452)	(705)	(253)	4,200	4,238	38	8,100	3,797	7,847
Lewisham and Greenwich NHS Trust	Yes	(11,609)	(12,335)	(726)	(20,200)	(20,926)	(726)	16,600	7,574	15,874
London Ambulance Service NHS Trust	Yes	(5,572)	(5,540)	32	(6,694)	(6,638)	56	2,050	1,025	2,050
London North West Healthcare NHS Trust	Yes	(30,660)	(31,253)	(593)	(61,500)	(61,500)	0	21,500	10,123	20,380
Moorfields Eye Hospital NHS Foundation Trust	Yes	3,421	3,540	118	2,631	2,750	119	1,100	550	1,100
North East London NHS Foundation Trust	Yes	204	2,589	2,385	462	924	462	2,260	1,130	2,260
North Middlesex University Hospital NHS Trust	Yes	9,494	3,115	(6,379)	14,100	14,100	0	9,800	2,450	9,678
Oxleas NHS Foundation Trust	Yes	240	243	3	2,580	2,583	3	1,580	790	1,580
Royal Brompton and Harefield NHS Foundation Trust	Yes	(3,017)	1,049	4,065	(7,493)	(7,493)	0	4,800	2,400	4,800
Royal Free London NHS Foundation Trust	Yes	2,374	(28,402)	(30,775)	15,500	(9,150)	(24,650)	18,300	4,575	9,150
Royal National Orthopaedic Hospital NHS Trust	Yes	(4,043)	(4,002)	41	(7,372)	(7,372)	0	1,000	456	915
South London And Maudsley NHS Foundation Trust	Yes	(4,762)	(3,802)	960	(3,981)	(3,939)	42	2,280	1,140	2,280
South West London and St George's Mental Health NHS Trust	Yes	(334)	(329)	5	2,108	2,108	0	990	495	990
St George's University Hospitals NHS Foundation Trust	Yes	(18,483)	(42,545)	(24,063)	(16,851)	(55,227)	(38,376)	17,600	0	0
Tavistock And Portman NHS Foundation Trust	Yes	401	1,180	778	800	800	0	500	250	500
The Hillingdon Hospitals NHS Foundation Trust	Yes	277	93	(184)	5,061	4,961	(100)	6,700	3,140	6,072
The Royal Marsden NHS Foundation Trust	Yes	(890)	(738)	152	(969)	(944)	25	1,500	750	1,500
The Whittington Hospital NHS Trust	Yes	(3,374)	(2,954)	420	(6,400)	(6,400)	0	6,500	3,047	6,500
University College London Hospitals NHS Foundation Trust	Yes	(10,012)	(6,995)	3,017	(11,000)	(11,000)	0	14,700	7,350	14,700
West London Mental Health NHS Trust	No	872	872	0	2,000	3,400	1,400	1,480	0	0
London Total		(190,077)	(271,445)	(81,368)	(225,765)	(297,085)	(71,321)	322,620	122,511	283,685

3.2 Financial performance by providers – Midlands and East (1/2)

NHS Improvement

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
Basildon And Thurrock University Hospitals NHS Foundation Trust	Yes	(6,154)	(6,807)	(652)	(15,443)	(18,005)	(2,562)	11,600	4,979	9,038
Bedford Hospital NHS Trust	Yes	(6,307)	(4,757)	1,550	(10,200)	(10,200)	0	5,800	2,646	5,184
Birmingham And Solihull Mental Health NHS Foundation Trust	Yes	(5,170)	(3,816)	1,353	372	373	0	1,370	685	1,370
Birmingham Children's Hospital NHS Foundation Trust	Yes	58	909	851	8,286	8,286	0	4,900	2,450	4,900
Birmingham Community Healthcare NHS Foundation Trust	Yes	1,308	1,511	203	3,910	3,910	(0)	1,610	805	1,610
Birmingham Women's NHS Foundation Trust	Yes	(1,733)	(1,370)	362	(1,500)	(1,500)	0	2,000	1,000	1,950
Black Country Partnership NHS Foundation Trust	Yes	(989)	(970)	19	(1,129)	(1,128)	1	610	305	610
Burton Hospitals NHS Foundation Trust	Yes	(6,083)	(6,337)	(254)	(9,885)	(9,884)	1	6,200	2,829	5,412
Cambridge University Hospitals NHS Foundation Trust	Yes	(34,801)	(29,902)	4,899	(56,333)	(56,333)	0	15,600	7,638	15,600
Cambridgeshire And Peterborough NHS Foundation Trust	Yes	272	339	67	1,447	1,447	1	1,170	585	1,170
Cambridgeshire Community Services NHS Trust	Yes	783	783	0	1,580	1,580	0	1,080	540	1,080
Chesterfield Royal Hospital NHS Foundation Trust	Yes	2,329	2,352	23	7,066	7,077	11	6,900	3,177	6,196
Colchester Hospital University NHS Foundation Trust	Yes	(14,749)	(14,533)	217	(31,707)	(31,708)	(1)	10,000	4,667	8,792
Coventry and Warwickshire Partnership NHS Trust	Yes	(818)	643	1,461	2,200	2,200	0	1,200	600	1,200
Derby Teaching Hospitals NHS Foundation Trust	Yes	(5,577)	(6,115)	(538)	(11,216)	(21,562)	(10,346)	13,600	6,205	9,180
Derbyshire Community Health Services NHS Foundation Trust	Yes	2,119	4,100	1,981	4,570	4,572	2	1,640	820	1,639
Derbyshire Healthcare NHS Foundation Trust	Yes	977	1,647	670	2,530	2,531	0	830	415	830
Dudley and Walsall Mental Health Partnership NHS Trust	Yes	722	781	59	1,700	1,700	0	500	250	500
East and North Hertfordshire NHS Trust	Yes	(7,608)	(7,574)	34	(8,650)	(8,650)	0	10,700	5,105	10,566
East Midlands Ambulance Service NHS Trust	Yes	(4,757)	(4,757)	0	(8,142)	(8,142)	0	759	253	759
East of England Ambulance Service NHS Trust	Yes	654	(3,638)	(4,292)	1,500	(6,206)	(7,706)	0	0	0
George Eliot Hospital NHS Trust	Yes	(7,300)	(7,251)	49	(14,715)	(14,715)	0	4,300	2,007	4,246
Heart Of England NHS Foundation Trust	Yes	(11,514)	(11,424)	90	(13,476)	(24,701)	(11,225)	23,300	11,650	17,475
Hertfordshire Community NHS Trust	Yes	(242)	444	686	1,530	1,530	0	880	440	880
Hertfordshire Partnership University NHS Foundation Trust	Yes	424	1,355	931	1,881	1,886	5	1,280	640	1,280
Hinchingbrooke Health Care NHS Trust	Yes	(5,695)	(8,847)	(3,152)	(9,800)	(9,800)	0	4,000	1,000	4,000
Ipswich Hospital NHS Trust	Yes	(11,164)	(11,134)	30	(20,105)	(20,105)	0	7,000	3,223	6,942
James Paget University Hospitals NHS Foundation Trust	Yes	(2,500)	(2,491)	9	2,374	2,178	(196)	5,800	2,719	5,256
Kettering General Hospital NHS Foundation Trust	Yes	(5,898)	(7,993)	(2,095)	(5,966)	(5,923)	43	7,600	3,799	7,599
Leicestershire Partnership NHS Trust	Yes	454	454	0	1,642	1,642	0	1,640	820	1,640
Lincolnshire Community Health Services NHS Trust	Yes	851	2,045	1,194	3,189	3,195	6	1,550	775	1,550
Lincolnshire Partnership NHS Foundation Trust	Yes	588	1,454	866	731	818	87	580	290	580
Luton And Dunstable University Hospital NHS Foundation Trust	Yes	623	721	98	11,817	12,043	226	9,100	4,550	9,100
Mid Essex Hospital Services NHS Trust	Yes	(12,294)	(12,044)	250	(26,600)	(26,600)	0	9,200	4,198	8,855
Milton Keynes University Hospital NHS Foundation Trust	Yes	(13,883)	(13,809)	74	(25,014)	(25,014)	(0)	7,300	3,650	7,300

3.2 Financial performance by providers – Midlands and East (2/2)

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
Norfolk And Norwich University Hospitals NHS Foundation Trust	No	(15,182)	(16,955)	(1,773)	(31,136)	(24,380)	6,757	14,400	0	0
Norfolk And Suffolk NHS Foundation Trust	Yes	(2,868)	(2,685)	183	(4,824)	(4,824)	0	1,270	635	1,270
Norfolk Community Health and Care NHS Trust	Yes	(473)	(121)	352	1,770	1,770	0	770	361	698
North Essex Partnership University NHS Foundation Trust	Yes	(743)	(2,734)	(1,991)	(3,026)	(6,539)	(3,514)	630	0	0
North Staffordshire Combined Healthcare NHS Trust	Yes	382	382	0	1,400	1,400	0	500	250	500
Northampton General Hospital NHS Trust	Yes	(7,199)	(6,957)	242	(15,129)	(15,129)	0	9,700	4,769	9,619
Northamptonshire Healthcare NHS Foundation Trust	Yes	72	166	94	1,340	1,340	0	1,140	570	1,140
Nottingham University Hospitals NHS Trust	Yes	(15,543)	(16,022)	(479)	(21,987)	(21,987)	0	24,200	11,041	22,335
Nottinghamshire Healthcare NHS Foundation Trust	Yes	4,489	4,681	192	8,130	8,130	0	2,730	1,365	2,730
Papworth Hospital NHS Foundation Trust	Yes	614	1,448	834	2,188	2,307	120	2,200	1,100	2,200
Peterborough and Stamford Hospitals NHS Foundation Trust	Yes	(10,064)	(10,078)	(14)	(20,150)	(19,956)	194	10,800	5,265	10,665
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust	Yes	(1,851)	(9,410)	(7,559)	(5,326)	(5,324)	2	6,500	0	6,446
Sandwell and West Birmingham Hospitals NHS Trust	Yes	(775)	(1,124)	(349)	6,600	6,600	0	11,300	5,297	10,241
Sherwood Forest Hospitals NHS Foundation Trust	Yes	(37,921)	(36,292)	1,629	(57,018)	(56,919)	98	10,300	5,064	10,214
Shrewsbury and Telford Hospital NHS Trust	Yes	(6,033)	(6,033)	0	(5,900)	(5,900)	0	10,500	5,250	10,500
Shropshire Community Health NHS Trust	Yes	114	121	7	800	800	0	700	328	700
South Essex Partnership University NHS Foundation Trust	Yes	(108)	1,965	2,072	257	257	(0)	1,430	715	1,430
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Yes	1,374	2,821	1,447	3,127	3,127	(0)	1,130	565	1,130
South Warwickshire NHS Foundation Trust	Yes	3,997	4,012	15	7,993	7,997	4	5,800	2,900	5,800
Southend University Hospital NHS Foundation Trust	Yes	(10,409)	(7,566)	2,843	(16,174)	(16,174)	(0)	8,200	4,100	8,200
Staffordshire and Stoke on Trent Partnership NHS Trust	No	(4,965)	(12,917)	(7,952)	(6,200)	(8,950)	(2,750)	700	0	0
The Dudley Group NHS Foundation Trust	Yes	4,978	5,028	50	9,870	9,870	(0)	10,500	5,250	10,500
The Princess Alexandra Hospital NHS Trust	Yes	(13,701)	(13,524)	177	(29,665)	(29,665)	0	7,900	3,703	7,571
The Robert Jones And Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Yes	1,045	595	(450)	1,987	1,987	0	500	125	500
The Royal Orthopaedic Hospital NHS Foundation Trust	Yes	(1,691)	(2,967)	(1,275)	(3,200)	(3,200)	(0)	200	0	198
The Royal Wolverhampton NHS Trust	Yes	(4,694)	(5,355)	(661)	7,082	5,139	(1,943)	10,600	4,615	8,657
United Lincolnshire Hospitals NHS Trust	Yes	(25,118)	(25,453)	(335)	(47,900)	(47,900)	0	16,100	6,843	13,484
University Hospitals Birmingham NHS Foundation Trust	Yes	3,200	3,400	200	4,600	4,800	200	16,700	7,828	15,134
University Hospitals Coventry and Warwickshire NHS Trust	Yes	234	(841)	(1,075)	1,100	1,100	0	17,200	7,525	17,200
University Hospitals of Leicester NHS Trust	Yes	(7,926)	(7,909)	17	(8,300)	(8,300)	0	23,400	11,700	23,400
University Hospitals of North Midlands NHS Trust	Yes	(5,907)	(7,430)	(1,523)	698	698	0	20,900	8,883	16,198
Walsall Healthcare NHS Trust	Yes	(4,523)	(7,691)	(3,168)	(6,136)	(6,136)	0	8,400	2,100	8,400
West Hertfordshire Hospitals NHS Trust	Yes	(14,328)	(14,164)	164	(22,553)	(22,553)	0	12,000	6,000	12,000
West Midlands Ambulance Service NHS Foundation Trust	Yes	2,462	2,590	128	1,952	1,949	(3)	1,340	670	1,340
West Suffolk NHS Foundation Trust	Yes	(4,564)	(3,868)	696	(5,000)	(5,000)	0	6,100	3,049	6,100
Worcestershire Acute Hospitals NHS Trust	Yes	(18,221)	(19,132)	(911)	(34,583)	(34,583)	0	13,100	5,568	12,254
Worcestershire Health and Care NHS Trust	Yes	1,599	2,100	501	4,200	4,200	0	1,200	600	1,200
Wye Valley NHS Trust	No	(14,418)	(16,860)	(2,442)	(28,500)	(31,500)	(3,000)	4,600	0	0
Midlands and East Total		(357,737)	(370,808)	(13,071)	(519,167)	(554,655)	(35,488)	477,239	209,748	424,243

3.3 Financial performance by providers – North (1/2)

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
5 Boroughs Partnership NHS Foundation Trust	Yes	(133)	(70)	62	(610)	(610)	(1)	1,090	545	1,090
Aintree University Hospital NHS Foundation Trust	Yes	(1,535)	(1,999)	(463)	1,285	698	(587)	9,500	4,256	8,907
Airedale NHS Foundation Trust	Yes	2,648	2,488	(160)	5,591	5,590	(0)	5,300	2,484	5,300
Alder Hey Childrens NHS Foundation Trust	Yes	(4,278)	(4,278)	1	(239)	(239)	0	3,700	1,850	3,700
Barnsley Hospital NHS Foundation Trust	Yes	(5,033)	(4,699)	334	(8,024)	(7,891)	133	6,600	3,300	6,600
Blackpool Teaching Hospitals NHS Foundation Trust	Yes	(2,210)	(2,105)	105	62	63	0	10,000	4,687	10,000
Bolton NHS Foundation Trust	Yes	4,221	4,340	120	11,901	11,902	1	9,200	4,313	8,913
Bradford District Care NHS Foundation Trust	Yes	666	(224)	(890)	2,140	2,140	(0)	790	0	790
Bradford Teaching Hospitals NHS Foundation Trust	Yes	5,443	5,467	24	9,009	9,043	34	11,000	4,812	11,000
Bridgewater Community Healthcare NHS Foundation Trust	Yes	(1,205)	(1,409)	(204)	(609)	(609)	(0)	1,550	774	1,550
Calderdale And Huddersfield NHS Foundation Trust	Yes	(9,771)	(9,727)	43	(16,153)	(16,150)	3	11,300	5,650	11,300
Calderstones Partnership NHS Foundation Trust	Yes	(1,161)	(864)	296	(1,161)	(864)	296	125	125	125
Central Manchester University Hospitals NHS Foundation Trust	Yes	(365)	883	1,248	5,918	5,918	0	20,200	10,100	20,200
Cheshire And Wirral Partnership NHS Foundation Trust	Yes	(879)	(483)	396	(890)	(886)	5	970	486	971
City Hospitals Sunderland NHS Foundation Trust	Yes	(953)	(925)	28	(2,167)	(2,167)	(1)	10,600	5,189	10,600
Countess Of Chester Hospital NHS Foundation Trust	Yes	(3,894)	(3,893)	1	(3,949)	(3,949)	1	5,900	2,949	5,899
County Durham And Darlington NHS Foundation Trust	Yes	1,729	2,089	360	6,659	6,662	3	15,600	7,800	15,600
Cumbria Partnership NHS Foundation Trust	Yes	(3,188)	(3,171)	18	(4,513)	(4,513)	(0)	1,960	980	1,960
Doncaster And Bassetlaw Hospitals NHS Foundation Trust	Yes	(14,318)	(10,447)	3,871	(26,468)	(17,783)	8,685	11,800	5,900	11,800
East Cheshire NHS Trust	Yes	(8,867)	(8,006)	861	(19,600)	(19,600)	0	4,600	2,300	4,600
East Lancashire Hospitals NHS Trust	Yes	(694)	(694)	0	(3,676)	(3,676)	0	12,500	5,859	12,500
Gateshead Health NHS Foundation Trust	Yes	290	545	256	296	294	(2)	6,300	3,150	6,300
Greater Manchester West Mental Health NHS Foundation Trust	No	1,368	1,383	15	3,573	3,587	13	1,020	0	0
Harrogate And District NHS Foundation Trust	Yes	2,903	2,942	39	6,895	6,894	(0)	4,600	2,300	4,600
Hull and East Yorkshire Hospitals NHS Trust	Yes	(435)	(931)	(496)	0	(2,358)	(2,358)	14,000	6,504	11,638
Humber NHS Foundation Trust	Yes	155	170	15	(330)	(325)	5	1,520	760	1,520
Lancashire Care NHS Foundation Trust	Yes	(696)	(3,125)	(2,429)	(1,390)	(1,390)	(0)	2,010	0	2,010
Lancashire Teaching Hospitals NHS Foundation Trust	Yes	(7,184)	(14,390)	(7,206)	(10,436)	(25,354)	(14,918)	9,900	0	0
Leeds And York Partnership NHS Foundation Trust	Yes	310	1,366	1,056	3,053	3,053	(0)	900	450	900
Leeds Community Healthcare NHS Trust	Yes	1,182	1,234	52	2,860	2,860	0	860	430	860
Leeds Teaching Hospitals NHS Trust	Yes	(5,168)	(5,112)	56	1,200	1,200	0	22,800	10,403	22,515
Liverpool Community Health NHS Trust	Yes	(635)	(606)	29	(1,610)	(1,610)	0	1,390	695	1,390
Liverpool Heart And Chest Hospital NHS Foundation Trust	Yes	(1,610)	(1,553)	57	(915)	(915)	0	2,200	1,100	2,200
Liverpool Womens NHS Foundation Trust	Yes	(3,478)	(3,442)	36	(6,992)	(6,994)	(2)	2,800	1,400	2,800
Manchester Mental Health and Social Care Trust	Yes	(976)	(962)	14	(1,890)	(1,890)	0	610	305	610
Mersey Care NHS Foundation Trust	Yes	3,433	3,433	(0)	7,077	7,077	0	1,655	765	1,655
Mid Cheshire Hospitals NHS Foundation Trust	Yes	312	313	0	(691)	(677)	13	6,500	3,047	5,891

3.3 Financial performance by providers – North (2/2)

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
Mid Yorkshire Hospitals NHS Trust	Yes	(4,982)	(4,728)	254	4,200	616	(3,584)	16,700	7,271	13,116
North Cumbria University Hospitals NHS Trust	Yes	(25,091)	(25,012)	79	(49,500)	(49,500)	0	8,700	4,042	8,700
North East Ambulance Service NHS Foundation Trust	Yes	(1,720)	931	2,651	(2,989)	(2,197)	792	710	355	710
North Tees And Hartlepool NHS Foundation Trust	Yes	(1,356)	625	1,982	2,134	2,165	32	7,900	3,851	7,801
North West Ambulance Service NHS Trust	Yes	541	768	227	1,860	1,860	0	1,860	930	1,860
Northern Lincolnshire And Goole NHS Foundation Trust	Yes	(8,404)	(9,029)	(625)	(11,986)	(11,969)	17	11,500	5,031	11,500
Northumberland, Tyne And Wear NHS Foundation Trust	Yes	2,622	1,689	(934)	6,576	6,576	(0)	1,830	915	1,830
Northumbria Healthcare NHS Foundation Trust	Yes	12,739	12,821	82	29,306	29,170	(136)	10,900	5,314	10,764
Pennine Acute Hospitals NHS Trust	Yes	(8,194)	(8,174)	20	(15,247)	(15,247)	0	20,500	9,823	20,500
Pennine Care NHS Foundation Trust	Yes	646	739	93	2,294	2,294	(0)	1,329	443	1,329
Rotherham Doncaster And South Humber NHS Foundation Trust	Yes	638	705	67	1,651	1,650	(1)	950	475	950
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Yes	4,750	4,932	182	15,900	15,900	0	9,700	4,850	9,700
Salford Royal NHS Foundation Trust	Yes	(7,423)	(1,531)	5,892	(4,099)	(4,098)	1	11,400	5,462	11,162
Sheffield Children's NHS Foundation Trust	Yes	(683)	(632)	51	2,352	2,352	0	2,100	1,050	2,100
Sheffield Health And Social Care NHS Foundation Trust	Yes	378	525	147	1,002	1,004	2	720	360	720
Sheffield Teaching Hospitals NHS Foundation Trust	Yes	2,941	3,191	249	5,000	3,594	(1,407)	19,300	9,248	17,893
South Tees Hospitals NHS Foundation Trust	Yes	(884)	(4,718)	(3,834)	8,536	8,536	0	14,600	7,302	14,600
South Tyneside NHS Foundation Trust	Yes	(3,206)	(2,286)	920	(2,918)	(3,071)	(153)	4,900	2,297	4,747
South West Yorkshire Partnership NHS Foundation Trust	Yes	1,329	1,356	26	1,850	1,858	8	1,350	675	1,350
Southport and Ormskirk Hospital NHS Trust	Yes	(3,587)	(11,686)	(8,099)	(6,600)	(6,600)	0	6,100	0	6,100
St Helens and Knowsley Hospital Services NHS Trust	Yes	1,354	1,366	12	3,328	3,328	0	10,100	5,050	10,100
Stockport NHS Foundation Trust	Yes	(13,975)	(11,047)	2,928	(6,504)	(16,056)	(9,552)	8,400	3,938	5,775
Tameside Hospital NHS Foundation Trust	Yes	(9,424)	(9,140)	284	(17,135)	(17,137)	(2)	6,900	3,450	6,469
Tees, Esk And Wear Valleys NHS Foundation Trust	Yes	6,854	7,908	1,054	10,057	10,546	489	1,980	990	1,980
The Christie NHS Foundation Trust	Yes	4,556	4,568	11	9,113	9,112	(1)	1,600	799	1,599
The Clatterbridge Cancer Centre NHS Foundation Trust	Yes	3,436	3,694	258	5,902	5,902	0	500	250	500
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	No	12,119	10,107	(2,012)	251	540	289	19,400	0	0
The Rotherham NHS Foundation Trust	Yes	2,123	2,150	27	6,653	6,653	0	6,500	3,250	6,500
The Walton Centre NHS Foundation Trust	Yes	(179)	(897)	(718)	1,021	1,021	(0)	1,300	324	1,300
University Hospital Of South Manchester NHS Foundation Trust	Yes	(4,559)	(4,559)	0	427	428	1	8,250	2,750	8,250
University Hospitals Of Morecambe Bay NHS Foundation Trust	Yes	(9,664)	(10,167)	(503)	(17,059)	(17,059)	0	10,200	5,100	10,200
Warrington And Halton Hospitals NHS Foundation Trust	Yes	(5,705)	(5,686)	20	(7,917)	(7,914)	3	8,000	4,000	8,000
Wirral Community NHS Foundation Trust	Yes	144	189	45	1,600	1,600	(0)	800	400	800
Wirral University Teaching Hospital NHS Foundation Trust	Yes	(3,102)	(3,280)	(178)	328	(468)	(797)	9,900	4,744	9,076
Wrightington, Wigan And Leigh NHS Foundation Trust	Yes	(370)	(266)	104	3,724	3,034	(689)	7,900	3,950	7,899
York Teaching Hospital NHS Foundation Trust	Yes	1,319	2,379	1,060	10,072	10,073	1	13,600	6,800	13,600
Yorkshire Ambulance Service NHS Trust	Yes	(1,820)	(772)	1,048	5,120	5,120	0	1,520	760	1,520
North Total		(109,843)	(109,428)	415	(46,489)	(69,853)	(23,364)	503,249	221,916	459,295

3.4 Financial performance by providers – South (1/2)

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
2Gether NHS Foundation Trust	Yes	(141)	(135)	6	673	679	5	650	325	650
Ashford and St Peter's Hospitals NHS Foundation Trust	Yes	6,863	6,742	(121)	12,966	12,966	0	8,400	4,078	8,365
Avon and Wiltshire Mental Health Partnership NHS Trust	Yes	(371)	(4,136)	(3,765)	2,480	2,480	0	1,260	315	1,260
Berkshire Healthcare NHS Foundation Trust	Yes	239	249	10	537	537	0	1,840	919	1,840
Brighton and Sussex University Hospitals NHS Trust	Yes	(14,055)	(23,666)	(9,611)	(15,570)	(59,700)	(44,130)	14,400	3,600	3,600
Buckinghamshire Healthcare NHS Trust	Yes	(1,184)	(1,101)	83	5,157	5,157	0	9,400	4,700	9,400
Cornwall Partnership NHS Foundation Trust	Yes	(1,290)	(1,238)	52	(450)	(448)	2	1,050	526	1,050
Dartford and Gravesham NHS Trust	Yes	2,548	2,666	118	6,121	6,189	68	9,000	4,219	9,000
Devon Partnership NHS Trust	Yes	820	837	17	2,460	2,463	3	860	430	860
Dorset County Hospital NHS Foundation Trust	Yes	(1,829)	(1,369)	459	(1,800)	(1,799)	0	4,700	2,056	4,700
Dorset Healthcare University NHS Foundation Trust	Yes	3,017	6,294	3,277	162	2,259	2,097	1,920	960	1,920
East Kent Hospitals University NHS Foundation Trust	Yes	(3,712)	(10,570)	(6,858)	612	(18,256)	(18,868)	16,100	4,025	4,025
East Sussex Healthcare NHS Trust	Yes	(19,742)	(24,734)	(4,992)	(31,300)	(31,300)	0	10,400	2,600	10,270
Frimley Health NHS Foundation Trust	Yes	8,859	7,989	(870)	23,472	22,111	(1,362)	21,800	10,446	20,438
Gloucestershire Care Services NHS Trust	Yes	605	611	6	1,793	1,793	0	1,080	540	1,080
Gloucestershire Hospitals NHS Foundation Trust	Yes	6,430	(8,702)	(15,132)	18,215	(23,771)	(41,986)	12,900	3,225	3,225
Great Western Hospitals NHS Foundation Trust	Yes	461	195	(266)	764	(68)	(832)	8,900	4,172	8,066
Hampshire Hospitals NHS Foundation Trust	Yes	1,253	1,458	205	6,776	6,793	17	10,300	5,150	10,300
Isle of Wight NHS Trust	Yes	(3,787)	(3,784)	3	(4,630)	(4,630)	0	3,500	1,641	3,500
Kent and Medway NHS and Social Care Partnership Trust	Yes	(2,558)	(2,557)	1	(4,090)	(4,090)	0	1,110	555	1,110
Kent Community Health NHS Foundation Trust	Yes	1,445	1,656	211	2,710	2,710	0	1,810	905	1,810
Maidstone and Tunbridge Wells NHS Trust	Yes	(11,024)	(11,400)	(376)	4,675	4,520	(155)	9,375	2,708	9,219
Medway NHS Foundation Trust	Yes	(23,638)	(22,836)	802	(43,686)	(43,686)	0	8,400	4,200	8,400
North Bristol NHS Trust	No	(26,273)	(28,973)	(2,700)	(48,033)	(52,000)	(3,967)	14,200	0	0
Northern Devon Healthcare NHS Trust	Yes	140	140	0	1,400	1,400	0	3,700	1,850	3,700
Oxford Health NHS Foundation Trust	Yes	(714)	224	938	(502)	(502)	(0)	2,030	1,015	2,030
Oxford University Hospitals NHS Foundation Trust	Yes	15,574	14,079	(1,495)	36,673	33,613	(3,060)	20,400	8,670	17,340
Plymouth Hospitals NHS Trust	No	(20,145)	(19,834)	311	(35,600)	(35,600)	0	11,900	0	0
Poole Hospital NHS Foundation Trust	Yes	(802)	(521)	281	(800)	(800)	0	7,900	3,950	7,900
Portsmouth Hospitals NHS Trust	Yes	(5,951)	(6,759)	(808)	1,200	1,078	(122)	14,600	6,418	14,478
Queen Victoria Hospital NHS Foundation Trust	Yes	1,327	1,328	1	2,215	2,215	(0)	900	415	786
Royal Berkshire NHS Foundation Trust	Yes	(169)	(432)	(263)	4,806	4,806	(1)	9,900	4,641	8,971
Royal Cornwall Hospitals NHS Trust	Yes	(2,243)	(2,241)	2	(3,677)	(3,677)	0	9,100	4,550	9,100
Royal Devon And Exeter NHS Foundation Trust	Yes	(3,976)	(865)	3,111	(6,390)	(6,456)	(66)	10,000	4,563	9,167
Royal Surrey County Hospital NHS Foundation Trust	Yes	(4,502)	963	5,465	(8,379)	(8,379)	(0)	7,700	3,272	5,968
Royal United Hospitals Bath NHS Foundation Trust	Yes	5,499	5,235	(264)	9,736	9,736	(0)	8,800	4,125	8,525
Salisbury NHS Foundation Trust	Yes	(3,605)	224	3,829	1,772	1,772	0	6,300	2,953	6,103
Solent NHS Trust	Yes	(3,269)	(1,482)	1,787	(3,413)	(3,413)	0	1,140	378	1,140

3.4 Financial performance by providers – South (2/2)

Provider Name	Control Total (CT) Accepted?	Control Total Basis Surplus Deficit Including STF						Sustainability & Transformation Fund (STF)		
		Year to date			Forecast Outturn					
		YTD Plan	YTD Actual	Variance	FOT Plan	FOT	Variance	STF Allocated (In Plan only if accepted CT)	YTD Actual	FOT
Somerset Partnership NHS Foundation Trust	Yes	963	979	16	2,892	2,892	(0)	2,090	1,045	2,090
South Central Ambulance Service NHS Foundation Trust	Yes	(815)	(2,531)	(1,716)	(830)	(2,679)	(1,849)	1,070	0	0
South East Coast Ambulance Service NHS Foundation Trust	No	138	(4,004)	(4,142)	859	(7,814)	(8,673)	0	0	0
South Western Ambulance Service NHS Foundation Trust	No	18	20	2	336	460	124	1,530	0	0
Southern Health NHS Foundation Trust	Yes	(290)	(575)	(285)	(380)	(1,700)	(1,320)	2,700	1,350	2,700
Surrey And Borders Partnership NHS Foundation Trust	Yes	502	(895)	(1,397)	1,060	1,060	0	960	0	960
Surrey and Sussex Healthcare NHS Trust	Yes	(1,854)	(1,765)	89	15,200	15,200	0	9,700	2,425	9,700
Sussex Community NHS Foundation Trust	Yes	774	(434)	(1,208)	4,370	4,370	(0)	1,970	0	1,970
Sussex Partnership NHS Foundation Trust	Yes	1,109	(2,581)	(3,690)	2,228	(2,268)	(4,496)	1,480	0	(0)
Taunton And Somerset NHS Foundation Trust	Yes	(5,408)	(3,236)	2,172	(1,059)	(1,754)	(695)	7,500	3,297	6,734
The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	Yes	(370)	(246)	125	(1,223)	(1,223)	1	7,600	3,800	7,600
Torbay and South Devon NHS Foundation Trust	Yes	(3,541)	(3,781)	(240)	2,276	(8,313)	(10,590)	6,700	3,210	3,210
University Hospital Southampton NHS Foundation Trust	Yes	(711)	6,288	6,998	16,280	16,282	3	17,400	8,700	17,400
University Hospitals Bristol NHS Foundation Trust	Yes	8,136	8,170	34	15,901	15,901	1	13,000	6,337	12,837
Western Sussex Hospitals NHS Foundation Trust	Yes	6,759	6,791	32	16,434	16,434	0	13,200	6,600	13,200
Weston Area Health NHS Trust	Yes	(1,947)	(1,947)	0	(3,200)	(3,200)	0	3,600	1,800	3,600
Yeovil District Hospital NHS Foundation Trust	Yes	(9,385)	(9,591)	(206)	(15,308)	(15,682)	(374)	4,500	2,015	4,125
South Total		(105,824)	(135,784)	(29,960)	(5,106)	(145,331)	(140,225)	382,725	149,675	305,422

4.0 Operational performance by providers

4.1 Best and worst operational performance (1/3)

A&E 4-hour standard – ten best and worst performing trusts during Q2 2016/17 - acute trusts only

Best performing trusts	Total attendances	4-hour breaches	Q2 2016/17 performance
Luton and Dunstable University Hospital NHS Foundation Trust	35,531	309	99.13%
Gateshead Health NHS Foundation Trust	28,618	840	97.06%
South Tees Hospitals NHS Foundation Trust	49,518	1,497	96.98%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	48,470	1,533	96.84%
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	25,117	1,022	95.93%
Surrey And Sussex Healthcare NHS Trust	24,286	993	95.91%
Northumbria Healthcare NHS Foundation Trust	51,752	2,165	95.82%
The Dudley Group NHS Foundation Trust	44,477	1,876	95.78%
South Warwickshire NHS Foundation Trust	18,124	768	95.76%
Epsom And St Helier University Hospitals NHS Trust	38,377	1,627	95.76%

Worst performing trusts	Total attendances	4-hour breaches	Q2 2016/17 performance
University Hospitals of North Midlands NHS Trust	60,419	11,607	80.79%
Mid Essex Hospital Services NHS Trust	24,951	4,798	80.77%
Portsmouth Hospitals NHS Trust	37,199	7,159	80.75%
Medway NHS Foundation Trust	29,536	5,701	80.70%
North Bristol NHS Trust	22,239	4,311	80.62%
University Hospitals Of Leicester NHS Trust	59,079	12,443	78.94%
United Lincolnshire Hospitals NHS Trust	40,728	8,854	78.26%
Stockport NHS Foundation Trust	24,277	5,658	76.69%
Nottingham University Hospitals NHS Trust	49,168	12,609	74.36%
The Princess Alexandra Hospital NHS Trust	25,805	6,706	74.01%

4.1 Best and worst operational performance (2/3)

RTT 18-week – ten best and worst performing trusts at end of Q2 2016/17 - acute and specialist trusts only

Best performing trusts	Waiting list	0-18 week waiters	Q2 2016/17 performance
The Christie NHS Foundation Trust	1,582	1,551	98.04%
Moorfields Eye Hospital NHS Foundation Trust	25,567	24,955	97.61%
North Middlesex University Hospital NHS Trust	7,977	7,779	97.52%
The Clatterbridge Cancer Centre NHS Foundation Trust	124	120	96.77%
Homerton University Hospital NHS Foundation Trust	16,518	15,932	96.45%
The Dudley Group NHS Foundation Trust	16,555	15,914	96.13%
Calderdale and Huddersfield NHS Foundation Trust	20,515	19,715	96.10%
Wrightington, Wigan and Leigh NHS Foundation Trust	17,093	16,423	96.08%
The Walton Centre NHS Foundation Trust	7,069	6,791	96.07%
The Royal Marsden NHS Foundation Trust	1,482	1,422	95.95%

Worst performing trusts	Waiting list	0-18 week waiters	Q2 2016/17 performance
Colchester Hospital University NHS Foundation Trust	24,992	21,225	84.93%
Taunton and Somerset NHS Foundation Trust	21,278	18,015	84.66%
Plymouth Hospitals NHS Trust	23,651	19,767	83.58%
University Hospital of South Manchester NHS Foundation Trust	28,291	23,213	82.05%
Northern Lincolnshire and Goole NHS Foundation Trust	26,740	21,887	81.85%
Imperial College Healthcare NHS Trust	58,484	47,745	81.64%
Lancashire Teaching Hospitals NHS Foundation Trust	41,420	33,557	81.02%
King's College Hospital NHS Foundation Trust	83,918	67,798	80.79%
Mid Yorkshire Hospitals NHS Trust	40,852	32,181	78.77%
Brighton And Sussex University Hospitals NHS Trust	34,883	26,800	76.83%

4.1 Best and worst operational performance (3/3)

Cancer 62-day standard – ten best and worst performing trusts in Q2 2016/17* - acute and specialist trusts only

Best performing trusts	Number treated	Within 62 days	Q2 2016/17 Performance
Kingston Hospital NHS Foundation Trust	149	141	94.30%
Wrightington, Wigan and Leigh NHS Foundation Trust	159	148	93.38%
Croydon Health Services NHS Trust	171	158	92.38%
Bolton NHS Foundation Trust	181	167	92.27%
Mid Cheshire Hospitals NHS Foundation Trust	198	182	92.15%
Tameside Hospital NHS Foundation Trust	114	104	91.63%
Royal United Hospitals Bath NHS Foundation Trust	277	253	91.32%
Calderdale and Huddersfield NHS Foundation Trust	238	217	91.18%
Airedale NHS Foundation Trust	118	107	91.06%
Barnsley Hospital NHS Foundation Trust	115	104	90.83%

Worst performing trusts	Number treated	Within 62 days	Q2 2016/17 Performance
The Christie NHS Foundation Trust	245	177	72.19%
University College London Hospitals NHS Foundation Trust	221	158	71.49%
Worcestershire Acute Hospitals NHS Trust	428	297	69.36%
East And North Hertfordshire NHS Trust	333	228	68.57%
Guy's and St Thomas' NHS Foundation Trust	330	225	68.29%
North Middlesex University Hospital NHS Trust	94	64	68.09%
Southend University Hospital NHS Foundation Trust	246	166	67.62%
The Clatterbridge Cancer Centre NHS Foundation Trust	143	87	60.70%
Royal National Orthopaedic Hospital NHS Trust	21	12	58.54%
Royal Brompton and Harefield NHS Foundation Trust	23	13	56.52%

** Trusts with l0 or fewer patients treated have not been included in this analysis*

4.2 Operational performance by providers - London

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
Barking, Havering And Redbridge University Hospitals NHS Trust	89.07%			0.16%	72.78%	94.49%	90.40%	99.61%	13
Barts Health NHS Trust	89.38%			0.60%	85.73%	97.39%	99.66%	98.18%	20
Central and North West London NHS Foundation Trust		100.00%	0	0.00%					
Central London Community Healthcare NHS Trust	99.77%	98.43%	0						
Chelsea and Westminster Hospital NHS Foundation Trust	94.53%	92.04%	0	0.44%	89.20%	92.72%	93.76%	98.98%	4
Croydon Health Services NHS Trust	92.00%	92.28%	2	0.81%	92.38%	97.59%	98.18%	97.89%	2
Epsom And St Helier University Hospitals NHS Trust	95.76%	90.62%	0	0.44%	87.22%	94.60%		98.37%	8
Great Ormond Street Hospital for Children NHS Foundation Trust				6.21%	100.00%			98.11%	0
Guy's and St Thomas' NHS Foundation Trust	89.69%	89.52%	20	1.19%	68.29%	89.18%	90.84%	97.01%	8
Homerton University Hospital NHS Foundation Trust	95.51%	96.45%	0	0.00%	83.82%	96.97%	97.91%	100.00%	1
Hounslow and Richmond Community Healthcare NHS Trust	99.98%	100.00%	0	0.00%					
Imperial College Healthcare NHS Trust	90.24%	81.64%	257	0.73%	80.09%	92.45%	93.33%	96.72%	14
King's College Hospital NHS Foundation Trust	84.53%	80.79%	146	0.97%	86.34%	95.11%	98.43%	97.68%	22
Kingston Hospital NHS Foundation Trust	92.48%	95.42%	0	0.22%	94.30%	98.08%	100.00%	100.00%	5
Lewisham and Greenwich NHS Trust	85.78%	91.70%	0	0.68%	82.20%	92.15%	88.56%	98.71%	6
London North West Healthcare NHS Trust	90.26%	91.56%	1	0.99%	77.34%	94.59%	96.91%	96.22%	7
Moorfields Eye Hospital NHS Foundation Trust	98.51%	97.61%	0	0.00%	0.00%	100.00%		96.55%	0
North East London NHS Foundation Trust	99.47%	99.70%	0		0.00%	100.00%			
North Middlesex University Hospital NHS Trust	89.67%	97.52%	0	0.67%	68.09%	95.23%	94.81%	99.58%	5
Royal Brompton and Harefield NHS Foundation Trust		90.34%	0	0.00%	56.52%	100.00%		98.11%	6
Royal Free London NHS Foundation Trust	89.77%	92.07%	5	0.15%	77.85%	94.33%	93.77%	96.65%	24
Royal National Orthopaedic Hospital NHS Trust		87.61%	0	3.74%	58.54%	99.77%		91.89%	1
South West London and ST George's Mental Health NHS Trust		96.39%	0						
St George's University Hospitals NHS Foundation Trust	93.14%			0.89%	88.13%	93.79%	94.49%	97.09%	7
The Hillingdon Hospitals NHS Foundation Trust	84.95%	92.38%	0	0.00%	85.23%	95.37%	99.41%	98.53%	4
The Royal Marsden NHS Foundation Trust		95.95%	0		75.31%	97.39%	95.54%	98.11%	14
The Whittington Hospital NHS Trust	91.29%	92.93%	0	0.28%	84.31%	97.23%	100.00%	100.00%	1
University College London Hospitals NHS Foundation Trust	89.13%	93.23%	0	4.76%	71.49%	89.22%	89.07%	95.56%	26
London	90.91%	89.64%	431	0.91%	80.43%	94.31%	95.21%	97.62%	198

4.2 Operational performance by providers – Midlands and East (1/2)

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
Basildon and Thurrock University Hospitals NHS Foundation Trust	87.54%	86.27%	1	15.11%	72.82%	90.72%	91.10%	98.21%	16
Bedford Hospital NHS Trust	90.49%	93.28%	0	0.29%	80.82%	94.13%	93.38%	99.02%	2
Birmingham Children's Hospital NHS Foundation Trust	96.46%	92.02%	0	0.00%	100.00%	100.00%		100.00%	1
Birmingham Community Healthcare NHS Foundation Trust	98.82%	93.48%	0			80.00%			
Birmingham Women's NHS Foundation Trust		95.00%	0	0.00%	88.24%	99.49%		100.00%	0
Black Country Partnership NHS Foundation Trust		97.84%	0						
Burton Hospitals NHS Foundation Trust	90.53%			1.28%	84.90%	96.19%	96.99%	98.51%	2
Cambridge University Hospitals NHS Foundation Trust	83.00%	89.97%	5	1.98%	81.51%	95.10%	98.41%	97.39%	15
Cambridgeshire and Peterborough NHS Foundation Trust		100.00%	0						
Cambridgshire Community Services NHS Trust		92.46%	0	0.00%					
Chesterfield Royal Hospital NHS Foundation Trust	88.58%	92.36%	0	0.71%	83.96%	94.75%	98.11%	99.70%	2
Colchester Hospital University NHS Foundation Trust	88.03%	84.93%	0	6.39%	73.15%	95.07%	93.46%	94.95%	10
Coventry and Warw ickshire Partnership NHS Trust		98.09%	0	0.00%					
Derby Teaching Hospitals NHS Foundation Trust	88.04%	92.06%	0	0.96%	80.13%	95.71%	96.16%	96.02%	18
Derbyshire Community Health Services NHS Foundation Trust	99.96%	97.27%	0	0.00%					
Derbyshire Healthcare NHS Foundation Trust		92.95%	0						
Dudley and Walsall Mental Health Partnership NHS Trust		95.63%	0						
East And North Hertfordshire NHS Trust	83.20%	92.06%	23	0.37%	68.57%	96.27%	91.77%	92.77%	3
George Eliot Hospital NHS Trust	91.67%	92.08%	0	0.08%	74.55%	96.25%	95.64%	100.00%	1
Heart of England NHS Foundation Trust	89.39%	92.73%	0	0.20%	90.34%	96.70%	95.28%	99.38%	27
Hertfordshire Community NHS Trust	100.00%	95.11%	0						
Hinchingbrooke Health Care NHS Trust	81.05%	93.28%	1	5.84%	89.58%	95.89%	97.32%	98.30%	2
Ipsw ich Hospital NHS Trust	91.32%	94.42%	1	3.03%	83.28%	95.23%	92.44%	96.48%	3
James Paget University Hospitals NHS Foundation Trust	89.52%	93.62%	0	0.00%	89.84%	96.95%	94.65%	99.71%	6
Kettering General Hospital NHS Foundation Trust	87.93%				88.98%	97.84%	97.67%	98.85%	3
Leicestershire Partnership NHS Trust		98.91%	0	0.00%					
Lincolnshire Community Health Services NHS Trust	98.79%								
Lincolnshire Partnership NHS Foundation Trust		92.13%	0						
Luton and Dunstable University Hospital NHS Foundation Trust	99.13%	92.56%	0	0.66%	89.64%	96.31%	96.69%	100.00%	4
Mid Essex Hospital Services NHS Trust	80.77%	91.40%	12	0.64%	74.30%	94.23%	92.98%	90.47%	6
Milton Keynes Hospital NHS Foundation Trust	93.78%	89.87%	30	1.87%	84.44%	94.93%	87.11%	100.00%	5
Norfolk and Norw ich University Hospitals NHS Foundation Trust	90.15%	86.22%	23	2.53%	80.70%	98.28%	98.91%	97.65%	14

4.2 Operational performance by providers – Midlands and East (2/2)

NHS Improvement

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
Norfolk Community Health and Care NHS Trust		91.42%	0						
Northampton General Hospital NHS Trust	90.91%	92.86%	0	0.46%	76.18%	96.60%	94.34%	96.72%	3
Northamptonshire Healthcare NHS Foundation Trust		100.00%	0						
Nottingham University Hospitals NHS Trust	74.36%	95.74%	1	0.21%	73.72%	92.67%	94.83%	96.20%	27
Papworth Hospital NHS Foundation Trust		93.36%	0	0.63%	75.00%			100.00%	0
Peterborough and Stamford Hospitals NHS Foundation Trust	83.05%	94.72%	0	1.07%	86.16%	97.88%	95.82%	100.00%	4
Sandwell And West Birmingham Hospitals NHS Trust	89.16%	91.20%	1	1.37%	86.78%	94.18%	95.34%	98.83%	9
Sherwood Forest Hospitals NHS Foundation Trust	95.16%	92.30%	1	4.02%	77.59%	94.83%	97.80%	97.10%	5
Shrewsbury And Telford Hospital NHS Trust	83.63%	88.86%	0	1.76%	88.30%	93.99%	93.65%	99.25%	4
Shropshire Community Health NHS Trust	99.99%	89.09%	1	0.00%					
South Essex Partnership University NHS Foundation Trust		100.00%	0						
South Warwickshire NHS Foundation Trust	95.76%	92.26%	0	1.36%	90.03%	95.82%	97.70%	99.57%	1
Southend University Hospital NHS Foundation Trust	84.21%	88.97%	1	0.81%	67.62%	93.30%	85.04%	96.18%	7
Staffordshire and Stoke on Trent Partnership NHS Trust		98.14%	0	0.00%					
The Dudley Group NHS Foundation Trust	95.78%	96.13%	0	1.88%	85.41%	94.64%	98.38%	99.25%	14
The Princess Alexandra Hospital NHS Trust	74.01%	92.13%	0	0.69%	87.61%	96.54%	93.00%	97.19%	6
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	94.33%	92.55%	0	0.45%	83.50%	97.80%	96.89%	99.08%	6
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust		87.14%	10	0.21%	88.89%	97.73%		83.33%	0
The Royal Orthopaedic Hospital NHS Foundation Trust		90.97%	28	0.08%	80.00%	100.00%		96.88%	1
The Royal Wolverhampton NHS Trust	90.44%	91.22%	51	1.00%	79.23%	93.94%	93.90%	96.25%	18
United Lincolnshire Hospitals NHS Trust	78.26%	88.64%	4	1.58%	74.56%	86.08%	45.78%	97.53%	15
University Hospitals Birmingham NHS Foundation Trust	83.26%	92.14%	0	0.14%	74.20%	95.09%	93.97%	97.18%	23
University Hospitals Coventry And Warwickshire NHS Trust	87.31%	87.98%	3	0.18%	85.97%	95.10%	98.73%	99.17%	10
University Hospitals Of Leicester NHS Trust	78.94%	91.65%	53	1.53%	79.94%	94.59%	96.32%	91.82%	16
University Hospitals of North Midlands NHS Trust	80.79%	88.58%	24	0.47%	74.66%	92.68%	92.84%	95.69%	31
Walsall Healthcare NHS Trust	86.29%			0.79%	88.14%	96.18%	95.60%	98.07%	3
West Hertfordshire Hospitals NHS Trust	84.43%	86.61%	0	0.08%	90.09%	87.16%	66.09%	96.74%	9
West Suffolk NHS Foundation Trust	87.45%	92.16%	1	8.22%	85.43%	94.79%	77.23%	100.00%	8
Worcestershire Acute Hospitals NHS Trust	84.07%	86.80%	1	2.36%	69.36%	70.74%	64.21%	98.12%	10
Worcestershire Health And Care NHS Trust	100.00%	98.27%	0			100.00%			
Wye Valley NHS Trust	86.20%		0	0.00%	82.99%	89.66%	65.93%	98.40%	7
Midlands and East	87.37%	90.91%	276	1.64%	80.42%	93.73%	89.99%	97.10%	377

4.2 Operational performance by providers – North (1/2)

NHS Improvement

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
5 Boroughs Partnership NHS Foundation Trust	100.00%								
Aintree University Hospital NHS Foundation Trust	84.86%	88.72%	0	0.63%	88.29%	96.65%	93.71%	99.73%	10
Airedale NHS Foundation Trust	90.16%	91.77%	0	0.00%	91.06%	98.49%	98.82%	99.54%	1
Alder Hey Children's NHS Foundation Trust	96.65%	92.04%	0	0.00%				100.00%	0
Barnsley Hospital NHS Foundation Trust	93.76%	94.22%	0	0.12%	90.83%	95.54%	94.12%	98.17%	3
Blackpool Teaching Hospitals NHS Foundation Trust	89.17%	94.58%	0	0.20%	85.24%	93.83%	99.19%	99.02%	3
Bolton NHS Foundation Trust	84.97%	92.94%	3	0.96%	92.27%	98.98%	95.83%	95.06%	11
Bradford District Care NHS Foundation Trust		100.00%	0						
Bradford Teaching Hospitals NHS Foundation Trust	89.38%	89.65%	0	0.53%	88.75%	96.57%	94.44%	99.23%	11
Bridgew ater Community Healthcare NHS Foundation Trust	99.22%	98.85%	1	1.09%		96.62%			
Calderdale and Huddersfield NHS Foundation Trust	94.46%	96.10%	0	0.16%	91.18%	98.01%	94.97%	99.46%	11
Central Manchester University Hospitals NHS Foundation Trust	92.98%	91.21%	0	3.45%	85.47%	94.76%		98.33%	17
City Hospitals Sunderland NHS Foundation Trust	94.30%	92.86%	0	0.63%	85.18%	95.70%		98.95%	5
Countess of Chester Hospital NHS Foundation Trust	90.17%	92.21%	0	6.07%	85.59%	95.83%	96.45%	97.37%	5
County Durham and Darlington NHS Foundation Trust	95.40%	92.87%	0	0.11%	87.07%	91.96%	88.46%	99.80%	4
Cumbria Partnership NHS Foundation Trust	99.09%	96.19%	0	1.16%					
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	93.00%	92.13%	1	1.06%	86.81%	94.61%	96.51%	99.78%	7
East Cheshire NHS Trust	82.40%	89.47%	1	0.50%	85.37%	98.23%	96.20%	100.00%	5
East Lancashire Hospitals NHS Trust	81.69%	93.90%	1	0.14%	85.59%	94.47%	97.56%	98.32%	10
Gateshead Health NHS Foundation Trust	97.06%	92.60%	0	0.81%	90.68%	97.48%	98.27%	99.71%	4
Harrogate and District NHS Foundation Trust	95.65%	94.78%	0	0.03%	86.67%	96.38%	97.83%	99.25%	9
Hull And East Yorkshire Hospitals NHS Trust	85.22%	87.93%	1	2.71%	79.04%	93.41%	96.59%	97.90%	13
Humber NHS Foundation Trust	99.92%	98.83%	0	0.00%	100.00%	100.00%			
Lancashire Care NHS Foundation Trust		95.69%	0						
Lancashire Teaching Hospitals NHS Foundation Trust	87.39%	81.02%	0	0.52%	83.04%	94.70%	93.08%	97.18%	11
Leeds Community Healthcare NHS Trust		100.00%	0	0.00%					
Leeds Teaching Hospitals NHS Trust	89.36%	88.63%	0	0.93%	76.01%	93.38%	95.34%	97.15%	27
Liverpool Community Health NHS Trust	99.98%			0.00%					
Liverpool Heart and Chest Hospital NHS Foundation Trust		92.37%	0	0.62%	87.18%	100.00%		99.28%	0

4.2 Operational performance by providers – North (2/2)

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
Liverpool Women's NHS Foundation Trust	97.78%	92.20%	0	0.00%	86.59%	96.63%		100.00%	0
Mid Cheshire Hospitals NHS Foundation Trust	91.34%	93.72%	0	0.11%	92.15%	98.33%	99.36%	99.66%	8
Mid Yorkshire Hospitals NHS Trust	84.68%	78.77%	1	0.38%	79.53%	95.65%	96.77%	95.86%	14
North Cumbria University Hospitals NHS Trust	90.05%	91.00%	0	0.51%	84.01%	98.55%	91.21%	97.54%	6
North Tees and Hartlepool NHS Foundation Trust	95.64%	92.39%	0	0.54%	83.33%	93.25%	96.84%	100.00%	10
Northern Lincolnshire and Goole NHS Foundation Trust	91.40%	81.85%	0	0.70%	88.63%	97.50%	96.76%	99.77%	4
Northumberland, Tyne and Wear NHS Foundation Trust		100.00%	0						
Northumbria Healthcare NHS Foundation Trust	95.82%	93.26%	0	0.00%	81.86%	94.64%	98.01%	97.38%	8
Pennine Acute Hospitals NHS Trust	84.39%	92.06%	0	5.44%	84.92%	93.92%	58.79%	99.77%	10
Pennine Care NHS Foundation Trust	99.99%			0.36%					
Royal Liverpool And Broadgreen University Hospitals NHS Trust	90.78%	90.06%	0	1.48%	86.47%	94.99%	94.63%	97.60%	14
Salford Royal NHS Foundation Trust	87.81%	92.79%	1	0.52%	89.05%	95.13%		97.59%	4
Sheffield Children's NHS Foundation Trust	97.84%	92.98%	0	0.56%	100.00%	100.00%		100.00%	1
Sheffield Teaching Hospitals NHS Foundation Trust	90.99%	92.97%	0	2.19%	81.87%	94.42%	98.40%	97.50%	31
South Tees Hospitals NHS Foundation Trust	96.98%	92.10%	0	1.06%	82.45%	92.48%	89.66%	97.14%	14
South Tyneside NHS Foundation Trust	92.41%	95.23%	0	0.00%	86.11%	95.95%		100.00%	3
South West Yorkshire Partnership NHS Foundation Trust		96.51%	0	0.00%					
Southport And Ormskirk Hospital NHS Trust	91.02%	92.83%	0	0.16%	85.93%	94.98%		98.06%	3
St Helens And Knowsley Hospitals NHS Trust	86.15%	93.17%	0	0.00%	87.86%	93.98%	95.45%	98.61%	11
Stockport NHS Foundation Trust	76.69%	91.15%	0	0.40%	88.45%	96.83%	98.94%	98.80%	12
Tameside Hospital NHS Foundation Trust	86.00%	93.07%	0	0.95%	91.63%	95.15%	95.37%	100.00%	10
The Christie NHS Foundation Trust		98.04%	0	0.00%	72.19%	100.00%		96.96%	9
The Clatterbridge Cancer Centre NHS Foundation Trust		96.77%	0	0.00%	60.70%			97.28%	2
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	96.84%	93.59%	0	1.62%	88.07%	95.60%	95.14%	98.38%	26
The Rotherham NHS Foundation Trust	92.20%	94.17%	0	1.81%	85.37%	94.66%	95.20%	98.73%	5
The Walton Centre NHS Foundation Trust		96.07%	0	0.67%		98.89%		100.00%	4
University Hospital of South Manchester NHS Foundation Trust	90.82%	82.05%	41	0.32%	88.27%	94.41%	92.39%	98.57%	7
University Hospitals of Morecambe Bay NHS Foundation Trust	83.82%	87.99%	0	0.82%	83.07%	95.19%	94.20%	98.30%	8
Warrington and Halton Hospitals NHS Foundation Trust	93.18%	93.50%	0	0.05%	85.59%	93.89%	93.33%	98.80%	4
Wirral Community NHS Trust	99.64%	100.00%	0	2.33%					
Wirral University Teaching Hospital NHS Foundation Trust	88.97%	88.61%	0	0.14%	89.19%	94.75%	96.86%	96.76%	14
Wrightington, Wigan and Leigh NHS Foundation Trust	91.17%	96.08%	0	0.90%	93.38%	98.35%	96.96%	100.00%	4
York Teaching Hospital NHS Foundation Trust	91.38%	90.78%	0	0.63%	84.30%	89.89%	93.31%	98.95%	6
North	90.72%	90.55%	51	1.13%	84.78%	95.02%	93.97%	98.20%	419

4.2 Operational performance by providers – South (1/2)

NHS Improvement

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
Ashford and St Peter's Hospitals NHS Foundation Trust	90.68%	92.83%	0	0.90%	83.51%	94.68%	94.81%	97.47%	5
Berkshire Healthcare NHS Foundation Trust	100.00%	99.44%	0	0.00%					
Brighton And Sussex University Hospitals NHS Trust	83.03%	76.83%	184	0.99%	78.50%	94.42%	97.33%	98.38%	19
Buckinghamshire Healthcare NHS Trust	92.08%	90.22%	1	0.65%	83.12%	94.75%	97.15%	98.00%	13
Cornwall Partnership NHS Foundation Trust	99.84%	100.00%	0	2.38%					
Dartford And Gravesham NHS Trust	88.88%	94.04%	0	0.24%	89.64%	94.00%	95.19%	100.00%	8
Dorset County Hospital NHS Foundation Trust	90.53%	86.29%	0	8.19%	85.47%	97.66%	98.08%	98.95%	3
Dorset Healthcare University NHS Foundation Trust	99.84%	98.85%	0	2.80%					
East Kent Hospitals University NHS Foundation Trust	83.10%	85.11%	27	0.26%	72.49%	95.32%	93.86%	93.76%	10
East Sussex Healthcare NHS Trust	80.88%	86.67%	0	2.55%	76.15%	97.18%	96.28%	98.56%	10
Frimley Health NHS Foundation Trust	91.47%	92.59%	0	0.33%	89.75%	94.87%	97.54%	99.29%	9
Gloucestershire Care Services NHS Trust	99.56%			0.00%					
Gloucestershire Hospitals NHS Foundation Trust	88.48%	90.20%	3	2.65%	77.18%	88.20%	93.69%	99.24%	10
Great Western Hospitals NHS Foundation Trust	88.96%	92.05%	7	4.42%	87.10%	84.14%	96.98%	97.34%	4
Hampshire Hospitals NHS Foundation Trust	88.13%	92.81%	0	0.25%	86.84%	97.29%	95.84%	99.61%	3
Isle Of Wight NHS Trust	86.93%	88.16%	0	0.50%	83.56%	98.02%	98.82%	100.00%	2
Kent Community Health NHS Trust	99.97%	99.52%	0	0.00%					
Maidstone And Tunbridge Wells NHS Trust	88.15%	90.36%	1	0.30%	75.72%	93.01%	89.61%	96.59%	11
Medway NHS Foundation Trust	80.70%			9.14%	81.74%	75.67%	87.07%	93.72%	10
North Bristol NHS Trust	80.62%	86.33%	56	6.01%	83.76%	89.87%	96.04%	96.79%	13
Northern Devon Healthcare NHS Trust	95.30%	92.73%	0	0.82%	83.71%	84.54%	41.94%	98.05%	1
Oxford Health NHS Foundation Trust	96.20%								
Oxford University Hospitals NHS Foundation Trust	85.71%	89.15%	15	0.95%	74.02%	94.91%	92.12%	93.62%	21
Oxleas NHS Foundation Trust		99.18%	0	0.00%					

4.2 Operational performance by providers – South (2/2)

NHS Improvement

ORGANISATION	A&E (95%)	RTT Incomplete (92%)	RTT 52 weeks	Diagnostics (<1.00%)	Cancer 62 days - GP referral (85%)	Cancer 2 weeks - GP referral (93%)	Cancer 2 weeks - breast symptoms (93%)	Cancer 31 days - GP referral (96%)	C.Diff cases
Plymouth Hospitals NHS Trust	84.68%	83.58%	67	2.19%	81.45%	94.28%	82.14%	95.25%	9
Poole Hospital NHS Foundation Trust	92.08%	92.37%	0	0.24%	89.98%	99.86%	100.00%	99.14%	2
Portsmouth Hospitals NHS Trust	80.75%	88.86%	0	0.96%	83.94%	96.68%	95.79%	98.62%	10
Queen Victoria Hospital NHS Foundation Trust	99.16%	91.57%	4	0.17%	81.16%	96.40%		95.05%	0
Royal Berkshire NHS Foundation Trust	91.80%	94.32%	13	0.48%	86.05%	96.21%	99.12%	97.32%	2
Royal Cornwall Hospitals NHS Trust	84.93%	92.98%	0	0.54%	86.84%	96.48%	98.41%	98.37%	7
Royal Devon and Exeter NHS Foundation Trust	90.01%	92.03%	1	2.53%	79.16%	96.49%	97.32%	97.20%	6
Royal Surrey County Hospital NHS Foundation Trust	87.07%	90.50%	0	4.29%	72.80%	99.08%	95.56%	96.74%	3
Royal United Hospitals Bath NHS Foundation Trust	83.31%	90.68%	0	0.80%	91.32%	92.72%	93.35%	100.00%	12
Salisbury NHS Foundation Trust	92.12%	92.16%	0	0.71%	89.58%	93.53%	96.15%	96.68%	1
Solent NHS Trust		98.70%	0		0.00%				
Somerset Partnership NHS Foundation Trust	99.63%	99.70%	0	0.00%					
Southern Health NHS Foundation Trust	99.09%	93.30%	0	0.00%					
Surrey And Sussex Healthcare NHS Trust	95.91%	92.43%	3	10.92%	86.36%	94.65%	95.63%	97.69%	12
Sussex Community NHS Trust	98.20%	99.23%	0	3.33%					
Taunton and Somerset NHS Foundation Trust	90.21%	84.66%	12	8.98%	83.43%	93.75%	94.08%	97.52%	4
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	95.93%	91.22%	0	0.04%	84.92%	97.12%	100.00%	97.53%	9
Torbay and South Devon NHS Foundation Trust	92.55%	89.34%	10	1.75%	88.13%	85.26%	98.48%	96.90%	8
University Hospital Southampton NHS Foundation Trust	93.75%	92.02%	1	0.36%	85.29%	95.18%	93.77%	96.91%	7
University Hospitals Bristol NHS Foundation Trust	88.89%	90.43%	1	3.12%	80.19%	93.56%		97.58%	10
Western Sussex Hospitals NHS Foundation Trust	94.20%	89.19%	0	0.88%	87.66%	94.08%	95.02%	98.20%	7
Weston Area Health NHS Trust	82.22%	95.38%	1	1.23%	73.74%	94.05%	84.88%	99.28%	0
Yeovil District Hospital NHS Foundation Trust	92.75%	89.61%	0	0.86%	83.63%	90.14%	92.97%	99.08%	1
South	90.12%	89.70%	407	2.22%	82.38%	93.58%	94.82%	97.38%	262

4.2 Operational performance by providers – Ambulance

	Red 1 (75%)	Red 2 (75%)	Cat A (95%)
East Midlands Ambulance Service NHS Trust	70.88%	57.34%	84.68%
East of England Ambulance Service NHS Trust	68.70%	61.50%	90.62%
Isle of Wight NHS Trust	65.45%	67.79%	89.78%
London Ambulance Service NHS Trust	69.03%	64.72%	93.33%
North East Ambulance Service NHS Foundation Trust	65.49%	65.03%	90.98%
North West Ambulance Service NHS Trust	70.87%	63.21%	89.97%
South Central Ambulance Service NHS Foundation Trust	70.38%	72.87%	94.40%
South East Coast Ambulance Service NHS Foundation Trust	63.11%	51.54%	89.18%

4.3 Operational performance by delivery boards – A&E (1/9)

The performance shown below cover all providers, including independent service providers

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
BANES A&E DELIVERY BOARD	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	21,461.00	3,582	83.31%		**83.31%**
	Total	**21,461.00**	**3,582**	**83.31%**		
BARNET & ENFIELD A&E DELIVERY BOARD	ROYAL FREE LONDON NHS FOUNDATION TRUST	65,018.00	6,653	89.77%		**90.15%**
	EDMONTON GP WALK IN CENTRE	2,556.00	0		100.00%	
	Total	**67,574.00**	**6,653**	**89.77%**	**100.00%**	
BARNSLEY A&E DELIVERY BOARD	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	21,113.00	1,318	93.76%		**93.76%**
	Total	**21,113.00**	**1,318**	**93.76%**		
BEDFORDSHIRE A&E DELIVERY BOARD	BEDFORD HOSPITAL NHS TRUST	18,378.00	1,748	90.49%		**92.81%**
	PUTNOE MEDICAL CENTRE WALK IN CENTRE	5,948.00	0		100.00%	
	Total	**24,326.00**	**1,748**	**90.49%**	**100.00%**	
BERKSHIRE EAST A&E DELIVERY BOARD	ASSURA READING LLP	10,036.00	0		100.00%	**100.00%**
	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	17,013.00	0		100.00%	
	Total	**27,049.00**	**0**		**100.00%**	
BERKSHIRE WEST A&E DELIVERY BOARD	ROYAL BERKSHIRE NHS FOUNDATION TRUST	31,534.00	2,585	91.80%		**92.21%**
	Total	31,534.00	2,585	91.80%		
BHR A&E DELIVERY BOARD	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	69,143.00	7,554	89.07%		
	NORTH EAST LONDON NHS FOUNDATION TRUST	14,612.00	78		99.47%	
	HAROLD WOOD WALK IN CENTRE	10,933.00	0		100.00%	
	ORCHARD VILLAGE WALK-IN-CENTRE	2,258.00	0		100.00%	
	THE PRACTICE LOXFORD	1,019.00	0		100.00%	
	Total	**97,965.00**	**7,632**	**89.07%**	**99.73%**	
BIRMINGHAM & SOLIHULL A&E DELIVERY BOARD	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	29,004.00	4,855	83.26%		**92.46%**
	HEART OF ENGLAND NHS FOUNDATION TRUST	67,302.00	7,138	89.39%		
	BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	13,395.00	474	96.46%		
	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	591.00	7		98.82%	
	ASSURA VERTIS URGENT CARE CENTRES (BIRMINGHAM)	13,751.00	0		100.00%	
	BIRMINGHAM WIC	9,463.00	0		100.00%	
	GREET GENERAL PRACTICE & URGENT CARE CENTRE	5,895.00	0		100.00%	
	SOLIHULL HEALTHCARE & WALK-IN-CENTRE	10,554.00	0		100.00%	
	SOUTH BIRMINGHAM GP WALK IN CENTRE	15,556.00	0		100.00%	
	Total	**165,511.00**	**12,474**	**88.64%**	**99.99%**	
BOLTON UEC DELIVERY BOARD	BOLTON NHS FOUNDATION TRUST	28,509.00	4,286	84.97%		**84.97%**
	Total	**28,509.00**	**4,286**	**84.97%**		
BRADFORD AND AIREDALE A&E DELIVERY BOARD	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	33,845.00	3,595	89.38%		**89.61%**
	AIREDALE NHS FOUNDATION TRUST	14,612.00	1,438	90.16%		
	Total	**48,457.00**	**5,033**	**89.61%**		
BRIGHTON A&E DELIVERY BOARD	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	41,867.00	7,105	83.03%		**83.03%**
	Total	**41,867.00**	**7,105**	**83.03%**		

4.3 Operational performance by delivery boards – A&E (2/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
BRISTOL, NORTH SOMERSET, SOUTH GLOUCESTERSHIRE (BNSSG) A&E DELIVERY BOARD	NORTH BRISTOL NHS TRUST	22,239.00	4,311	80.62%		88.68%
	WESTON AREA HEALTH NHS TRUST	14,565.00	2,590	82.22%		
	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	32,070.00	3,564	88.89%		
	BRISTOL COMMUNITY HEALTH	15,531.00	254		98.36%	
	YATE WEST GATE CENTRE	4,791.00	28		99.42%	
	PAULTON MEMORIAL HOSPITAL	2,023.00	2		99.90%	
	CLEVEDON HOSPITAL	3,747.00	0		100.00%	
	Total	**94,966.00**	**10,749**	**84.81%**	**98.91%**	
BROMLEY A&E DELIVERY BOARD	BECKENHAM BEACON UCC	12,965.00	4		99.97%	**99.99%**
	URGENT CARE CENTRE	27,975.00	0		100.00%	
	Total	**40,940.00**	**4**		**99.99%**	
BUCKINGHAMSHIRE A&E DELIVERY BOARD	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	35,897.00	2,842	92.08%		**92.08%**
	Total	**35,897.00**	**2,842**	**92.08%**		
CALDERDALE AND HUDDERSFIELD A&E DELIVERY BOARD	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	38,373.00	2,127	94.46%		**96.13%**
	LCD-LEEDS-OOH	7,819.00	0		100.00%	
	LOCAL CARE DIRECT OOH	8,806.00	0		100.00%	
	Total	**54,998.00**	**2,127**	**94.46%**	**100.00%**	
CAMBRIDGE & ELY A&E DELIVERY BOARD	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	38,472.00	6,540	83.00%		**83.00%**
	Total	**38,472.00**	**6,540**	**83.00%**		
CAMDEN A&E DELIVERY BOARD	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	34,824.00	3,785	89.13%		**89.13%**
	Total	**34,824.00**	**3,785**	**89.13%**		
CENTRAL CHESHIRE A&E DELIVERY BOARD	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	22,258.00	1,928	91.34%		**91.34%**
	Total	**22,258.00**	**1,928**	**91.34%**		
CENTRAL LANCASHIRE A&E DELIVERY BOARD	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	32,907.00	4,150	87.39%		**87.39%**
	Total	**32,907.00**	**4,150**	**87.39%**		
CENTRAL NORFOLK A&E DELIVERY BOARD	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	33,785.00	3,327	90.15%		**93.47%**
	NORWICH PRACTICES LTD (CASTLE MALL)	17,132.00	0		100.00%	
	Total	**50,917.00**	**3,327**	**90.15%**	**100.00%**	
CHELWEST A&E DELIVERY BOARD	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	68,948.00	3,773	94.53%		**96.87%**
	CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	55,507.00	125		99.77%	
	Total	**124,455.00**	**3,898**	**94.53%**	**99.77%**	
CITY & HACKNEY HEALTH AND SOCIAL CARE TRANSFORMATION BOARD	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	30,524.00	1,371	95.51%		**96.94%**
	ORIENT PRACTICE	1,673.00	4		99.76%	
	ST ANDREWS WALK-IN CENTRE	5,399.00	0		100.00%	
	THE BARKANTINE PRACTICE	7,308.00	0		100.00%	
	Total	**44,904.00**	**1,375**	**95.51%**	**99.97%**	
COASTAL WEST SUSSEX A&E DELIVERY BOARD	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	36,819.00	2,134	94.20%		**94.56%**
	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	2,867.00	24		99.16%	
	Total	**39,686.00**	**2,158**	**94.20%**	**99.16%**	
CORNWALL A&E DELIVERY BOARD	ROYAL CORNWALL HOSPITALS NHS TRUST	25,218.00	3,800	84.93%		**93.31%**
	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	32,333.00	53		99.84%	
	Total	**57,551.00**	**3,853**	**84.93%**	**99.84%**	
COVENTRY & RUGBY A&E DELIVERY BOARD	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	46,968.00	5,962	87.31%		**89.81%**
	COVENTRY NHS HEALTHCARE CTR	11,567.00	0		100.00%	
	Total	**58,535.00**	**5,962**	**87.31%**	**100.00%**	

4.3 Operational performance by delivery boards – A&E (3/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
CROYDON A&E DELIVERY BOARD	CROYDON HEALTH SERVICES NHS TRUST	29,898.00	2,392	92.00%		
	EDRIDGE ROAD COMMUNITY HEALTH CENTRE	7,344.00	0		100.00%	
	PARKWAY MIU	1,667.00	0		100.00%	**94.16%**
	PURLEY MIU	2,063.00	0		100.00%	
	Total	**40,972.00**	**2,392**	**92.00%**	**100.00%**	
DEVON A&E DELIVERY BOARD	PLYMOUTH HOSPITALS NHS TRUST	25,776.00	3,950	84.68%		
	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	25,982.00	2,595	90.01%		
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	30,567.00	2,276	92.55%		
	NORTHERN DEVON HEALTHCARE NHS TRUST	32,107.00	1,510	95.30%		**91.90%**
	LIVEWELL SOUTHWEST	12,593.00	0		100.00%	
	OKEHAMPTON MEDICAL CENTRE	544.00	0		100.00%	
	Total	**127,569.00**	**10,331**	**90.97%**	**100.00%**	
DGS (ALSO CALLED NORTH KENT) A&E DELIVERY BOARD	DARTFORD AND GRAVESHAM NHS TRUST	29,142.00	3,240	88.88%		**88.88%**
	Total	**29,142.00**	**3,240**	**88.88%**		
DONCASTER & BASSETLAW A&E DELIVERY BOARD	DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	43,665.00	3,056	93.00%		**93.00%**
	Total	**43,665.00**	**3,056**	**93.00%**		
DORSET A&E DELIVERY BOARD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	11,810.00	1,118	90.53%		
	POOLE HOSPITAL NHS FOUNDATION TRUST	17,505.00	1,386	92.08%		
	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	25,117.00	1,022	95.93%		**95.21%**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	19,761.00	31		99.84%	
	Total	**74,193.00**	**3,557**	**93.52%**	**99.84%**	
DUDLEY A&E DELIVERY BOARD	THE DUDLEY GROUP NHS FOUNDATION TRUST	44,477.00	1,876	95.78%		**95.78%**
	Total	**44,477.00**	**1,876**	**95.78%**		
DURHAM AND DARLINGTON A&E DELIVERY BOARD	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	71,484.00	3,287	95.40%		**95.40%**
	Total	**71,484.00**	**3,287**	**95.40%**		
EAST & NORTH HERTFORDSHIRE A&E DELIVERY BOARD	EAST AND NORTH HERTFORDSHIRE NHS TRUST	40,280.00	6,767	83.20%		
	HAVERSTOCK HEALTHCARE (CHESHUNT COMMUNITY HOSPITAL)	6,019.00	0		100.00%	**86.22%**
	HERTFORDSHIRE COMMUNITY NHS TRUST	2,795.00	0		100.00%	
	Total	**49,094.00**	**6,767**	**83.20%**	**100.00%**	
EAST KENT A&E DELIVERY BOARD	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	54,450.00	9,200	83.10%		
	DR JM RIBCHESTER & PARTNERS	7,111.00	0		100.00%	**85.06%**
	Total	**61,561.00**	**9,200**	**83.10%**	**100.00%**	
EAST STAFFORDSHIRE A&E DELIVERY BOARD	BURTON HOSPITALS NHS FOUNDATION TRUST	30,394.00	2,879	90.53%		**90.53%**
	Total	**30,394.00**	**2,879**	**90.53%**		
EAST SUSSEX A&E DELIVERY BOARD	EAST SUSSEX HEALTHCARE NHS TRUST	29,325.00	5,608	80.88%		
	SUSSEX COMMUNITY NHS FOUNDATION TRUST	28,184.00	508		98.20%	**89.37%**
	Total	**57,509.00**	**6,116**	**80.88%**	**98.20%**	
EASTERN CHESHIRE A&E DELIVERY BOARD	EAST CHESHIRE NHS TRUST	13,554.00	2,385	82.40%		**82.40%**
	Total	**13,554.00**	**2,385**	**82.40%**		
EPSOM ST HELIER A&E DELIVERY BOARD	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	38,377.00	1,627	95.76%		**95.76%**
	Total	**38,377.00**	**1,627**	**95.76%**		

4.3 Operational performance by delivery boards – A&E (4/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
Essex Success Regime	MID ESSEX HOSPITAL SERVICES NHS TRUST	24,951.00	4,798	80.77%		84.52%
	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	26,017.00	4,109	84.21%		
	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	33,579.00	4,184	87.54%		
	Total	**84,547.00**	**13,091**	**84.52%**		
FLYDE COAST A&E DELIVERY BOARD	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	51,731.00	5,603	89.17%		89.17%
	Total	**51,731.00**	**5,603**	**89.17%**		
FRIMLEY SOUTH A&E DELIVERY BOARD	FRIMLEY HEALTH NHS FOUNDATION TRUST	60,960.00	5,202	91.47%		91.47%
	Total	**60,960.00**	**5,202**	**91.47%**		
GATESHEAD & NEWCASTLE A&E DELIVERY BOARD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	48,470.00	1,533	96.84%		96.92%
	GATESHEAD HEALTH NHS FOUNDATION TRUST	28,618.00	840	97.06%		
	Total	**77,088.00**	**2,373**	**96.92%**		
GLOUCESTERSHIRE A&E DELIVERY BOARD	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	34,607.00	3,985	88.48%		92.62%
	GLOUCESTERSHIRE CARE SERVICES NHS TRUST	19,812.00	87		99.56%	
	TETBURY HOSPITAL TRUST LTD	724.00	0		100.00%	
	Total	**55,143.00**	**4,072**	**88.48%**	**99.58%**	
GREAT YARMOUTH & WAVENEY A&E DELIVERY BOARD	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	20,297.00	2,127	89.52%		92.05%
	EAST COAST COMMUNITY HEALTHCARE C.I.C	1,968.00	0		100.00%	
	GREYFRIARS HEALTH CENTRE	4,500.00	0		100.00%	
	Total	**26,765.00**	**2,127**	**89.52%**	**100.00%**	
GREATER NOTTINGHAM A&E DELIVERY BOARD	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	49,168.00	12,609	74.36%		80.15%
	NOTTINGHAM CITY CARE PARTNERSHIP	15,058.00	142		99.06%	
	Total	**64,226.00**	**12,751**	**74.36%**	**99.06%**	
GUILDFORD AND WAVERLEY A&E DELIVERY BOARD	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	17,647.00	2,282	87.07%		87.07%
	Total	**17,647.00**	**2,282**	**87.07%**		
HAMBLETON, RICHMOND & WHITBY AND SOUTH TEES A&E DELIVERY BOARD	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	49,518.00	1,497	96.98%		89.67%
	Total	49,518.00	1,497	96.98%		
HARINGEY LOCAL A&E DELIVERY BOARD	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	38,843.00	4,014	89.67%		
	Total	**38,843.00**	**4,014**	**89.67%**		
HARROGATE AND RURAL DISTRICT A&E DELIVERY BOARD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	15,078.00	656	95.65%		95.65%
	Total	**15,078.00**	**656**	**95.65%**		
HEREFORDSHIRE A&E DELIVERY BOARD	WYE VALLEY NHS TRUST	23,189.00	3,200	86.20%		86.20%
	Total	**23,189.00**	**3,200**	**86.20%**		
HERTS VALLEY A&E DELIVERY BOARD	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	36,138.00	5,626	84.43%		84.43%
	Total	**36,138.00**	**5,626**	**84.43%**		
HILLINGDON A&E DELIVERY BOARD	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	40,013.00	6,020	84.95%		87.71%
	THE RIDGEWAY SURGERY	8,958.00	0		100.00%	
	Total	**48,971.00**	**6,020**	**84.95%**	**100.00%**	
HOUNSLOW A&E DELIVERY BOARD	HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	13,694.00	3		99.98%	99.98%
	Total	**13,694.00**	**3**		**99.98%**	

4.3 Operational performance by delivery boards – A&E (5/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
HULL & EAST YORKSHIRE A&E DELIVERY BOARD	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	37,952.00	5,609	85.22%		88.56%
	HUMBER NHS FOUNDATION TRUST	6,121.00	5		99.92%	
	BRANSHOLME HEALTH CENTRE	3,661.00	0		100.00%	
	FREEDOM CENTRE	1,337.00	0		100.00%	
	Total	**49,071.00**	**5,614**	**85.22%**	**99.96%**	
ICHT A&E DELIVERY BOARD	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	72,764.00	7,104	90.24%		90.24%
	Total	**72,764.00**	**7,104**	**90.24%**		
IPSWICH & EAST SUFFOLK A&E DELIVERY BOARD	IPSWICH HOSPITAL NHS TRUST	24,524.00	2,128	91.32%		91.32%
	Total	**24,524.00**	**2,128**	**91.32%**		
ISLE OF WIGHT A&E DELIVERY BOARD	ISLE OF WIGHT NHS TRUST	17,318.00	2,263	86.93%		86.93%
	Total	**17,318.00**	**2,263**	**86.93%**		
ISLINGTON A&E DELIVERY BOARD	THE WHITTINGTON HOSPITAL NHS TRUST	23,810.00	2,074	91.29%		95.05%
	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	25,909.00	387		98.51%	
	Total	**49,719.00**	**2,461**	**91.29%**	**98.51%**	
KINGSTON & RICHMOND A&E DELIVERY BOARD	KINGSTON HOSPITAL NHS FOUNDATION TRUST	28,903.00	2,173	92.48%		92.48%
	Total	**28,903.00**	**2,173**	**92.48%**		
LAMBETH & SOUTHWARK A&E DELIVERY BOARD	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	72,202.00	11,171	84.53%		87.59%
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	48,041.00	4,954	89.69%		
	THE JUNCTION HC - UNREGISTERED PATIENTS	9,692.00	0		100.00%	
	Total	**129,935.00**	**16,125**	**86.59%**	**100.00%**	
LEEDS A&E DELIVERY BOARD	LEEDS TEACHING HOSPITALS NHS TRUST	59,996.00	6,381	89.36%		89.36%
	Total	**59,996.00**	**6,381**	**89.36%**		
LEICESTER, LEICESTERSHIRE & RUTLAND A&E DELIVERY BOARD	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	59,079.00	12,443	78.94%		85.35%
	LOUGHBOROUGH URGENT CARE CENTRE	11,192.00	182		98.37%	
	OADBY & WIGSTON URGENT CARE CENTRE	8,290.00	27		99.67%	
	MARKET HARBOROUGH URGENT CARE CENTRE	1,844.00	5		99.73%	
	OAKHAM URGENT CARE CENTRE	948.00	1		99.89%	
	LATHAM HOUSE MEDICAL PRACTICE	1,364.00	0		100.00%	
	MARKET HARBOROUGH MED.CTR	1,180.00	0		100.00%	
	MELTON MOWBRAY URGENT CARE CENTRE	1,531.00	0		100.00%	
	OAKHAM MEDICAL PRACTICE	1,001.00	0		100.00%	
	Total	**86,429.00**	**12,658**	**78.94%**	**99.21%**	
LEWISHAM, GREENWICH AND BEXLEY A&E DELIVERY BOARD	LEWISHAM AND GREENWICH NHS TRUST	67,865.00	9,651	85.78%		87.17%
	WALDRON - HURLEY UNREGISTERED PRACTICE	7,385.00	0		100.00%	
	Total	**75,250.00**	**9,651**	**85.78%**	**100.00%**	
LINCOLNSHIRE A&E DELIVERY BOARD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	40,728.00	8,854	78.26%		90.26%
	LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	42,462.00	515		98.79%	
	Total	83,190.00	9,369	78.26%	98.79%	
LNWHT A&E DELIVERY BOARD	LONDON NORTH WEST HEALTHCARE NHS TRUST	84,136.00	8,197	90.26%		
	Total	**84,136.00**	**8,197**	**90.26%**		

4.3 Operational performance by delivery boards – A&E (6/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
LUTON A&E DELIVERY BOARD	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	35,531.00	309	99.13%		**99.13%**
	Total	**35,531.00**	**309**	**99.13%**		
MANCHESTER CITY-WIDE URGENT CARE TRANSFORMATION AND DELIVERY BOARD	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	24,729.00	2,270	90.82%		**92.46%**
	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	77,968.00	5,471	92.98%		
	Total	**102,697.00**	**7,741**	**92.46%**		
MEDWAY & SWALE A&E DELIVERY BOARD	MEDWAY NHS FOUNDATION TRUST	29,536.00	5,701	80.70%		**80.70%**
	Total	**29,536.00**	**5,701**	**80.70%**		
MID MERSEY, WARRINGTON &HALTON A&E DELIVERY BOARD	ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	42,579.00	5,899	86.15%		**92.31%**
	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	60,163.00	5,549	90.78%		
	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	30,234.00	2,063	93.18%		
	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	13,289.00	445	96.65%		
	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	3,327.00	74		97.78%	
	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	24,374.00	189		99.22%	
	LIVERPOOL COMMUNITY HEALTH NHS TRUST	5,611.00	1		99.98%	
	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	5,265.00	0		100.00%	
	Total	**184,842.00**	**14,220**	**90.46%**	**99.32%**	
MID YORKSHIRE A&E DELIVERY BOARD	MID YORKSHIRE HOSPITALS NHS TRUST	59,919.00	9,177	84.68%		**84.68%**
	Total	**59,919.00**	**9,177**	**84.68%**		
MID-NOTTINGHAMSHIRE A&E DELIVERY BOARD	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	37,865.00	1,831	95.16%		**95.16%**
	Total	**37,865.00**	**1,831**	**95.16%**		
MILTON KEYNES A&E DELIVERY BOARD	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	36,119.00	2,245	93.78%		**93.78%**
	Total	**36,119.00**	**2,245**	**93.78%**		
MORECAMBE BAY A&E DELIVERY BOARD	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	28,317.00	4,581	83.82%		**83.82%**
	Total	**28,317.00**	**4,581**	**83.82%**		
NORHT TEES A&E DELIVERY BOARD	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	23,354.00	1,018	95.64%		**95.64%**
	Total	**23,354.00**	**1,018**	**95.64%**		
NORTH AND MID HAMPSHIRE A&E DELIVERY BOARD	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	31,360.00	3,721	88.13%		**91.90%**
	ST MARY'S NHS TREATMENT CENTRE	15,015.00	34		99.77%	
	Total	**46,375.00**	**3,755**	**88.13%**	**99.77%**	
NORTH EAST ESSEX A&E DELIVERY BOARD	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	22,217.00	2,659	88.03%		**94.41%**
	FRYATT HOSPITAL	2,217.00	11		99.50%	
	CLACTON HOSPITAL	8,952.00	12		99.87%	
	NORTH COLCHESTER HEALTHCARE CENTRE	14,592.00	0		100.00%	
	Total	**47,978.00**	**2,682**	**88.03%**	**99.91%**	
NORTH EAST SECTOR UEC DELIVERY BOARD	PENNINE ACUTE HOSPITALS NHS TRUST	78,859.00	12,310	84.39%		**86.83%**
	PENNINE CARE NHS FOUNDATION TRUST	14,595.00	1		99.99%	
	Total	**93,454.00**	**12,311**	**84.39%**	**99.99%**	
NORTH LINCOLNSHIRE AND NORTH EAST LINCOLNSHIRE A&E DELIVERY BOARD	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	39,876.00	3,430	91.40%		**91.40%**
	Total	**39,876.00**	**3,430**	**91.40%**		
NORTH MERSEY & SOUTHPORT A&E DELIVERY BOARD	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	41,761.00	6,323	84.86%		**87.61%**
	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	33,788.00	3,035	91.02%		
	Total	**75,549.00**	**9,358**	**87.61%**		

4.3 Operational performance by delivery boards – A&E (7/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
NORTH NORTHAMPTONSHIRE A&E DELIVERY BOARD	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	22,358.00	2,699	87.93%		**93.02%**
	CORBY URGENT CARE CENTRE	17,209.00	61		99.65%	
	Total	**39,567.00**	**2,760**	**87.93%**	**99.65%**	
NORTH STAFFS/UHNM A&E DELIVERY BOARD	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	60,419.00	11,607	80.79%		**80.79%**
	Total	**60,419.00**	**11,607**	**80.79%**		
NORTH TYNESIDE AND NORTHUMBERLAND A&E DELIVERY BOARD	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	51,752.00	2,165	95.82%		**95.82%**
	Total	**51,752.00**	**2,165**	**95.82%**		
NORTHERN DERBYSHIRE A&E DELIVERY BOARD	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	20,511.00	2,342	88.58%		**93.50%**
	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	15,600.00	6		99.96%	
	Total	**36,111.00**	**2,348**	**88.58%**	**99.96%**	
NW SURREY A&E DELIVERY BOARD	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	28,760.00	2,679	90.68%		**92.93%**
	ASHFORD HEALTH CENTRE	9,241.00	8		99.91%	
	Total	**38,001.00**	**2,687**	**90.68%**	**99.91%**	
OXFORDSHIRE A&E DELIVERY BOARD	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	38,414.00	5,491	85.71%		**87.78%**
	OXFORD HEALTH NHS FOUNDATION TRUST	9,441.00	359		96.20%	
	Total	**47,855.00**	**5,850**	**85.71%**	**96.20%**	
PENNIE LANCASHIRE A&E DELIVERY BOARD	EAST LANCASHIRE HOSPITALS NHS TRUST	45,515.00	8,332	81.69%		**85.23%**
	LINDLEY HOUSE HEALTH CENTRE	10,911.00	0		100.00%	
	Total	**56,426.00**	**8,332**	**81.69%**	**100.00%**	
Peterborough, Stamford & Hinchingbrooke	HINCHINGBROOKE HEALTH CARE NHS TRUST	12,146.00	2,302	81.05%		**82.43%**
	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	26,938.00	4,567	83.05%		
	Total	**39,084.00**	**6,869**	**82.43%**		
PORTSMOUTH AND SE HANTS A&E DELIVERY BOARD	PORTSMOUTH HOSPITALS NHS TRUST	37,199.00	7,159	80.75%		**80.75%**
	Total	**37,199.00**	**7,159**	**80.75%**		
ROTHERHAM A&E DELIVERY BOARD	THE ROTHERHAM NHS FOUNDATION TRUST	19,737.00	1,539	92.20%		**95.04%**
	CARE UK NHS ROTHERHAM DIAGNOSTIC CENTRE	11,295.00	0		100.00%	
	Total	**31,032.00**	**1,539**	**92.20%**	**100.00%**	
SALFORD UEC DELIVERY BOARD	SALFORD ROYAL NHS FOUNDATION TRUST	25,215.00	3,073	87.81%		**87.81%**
	Total	**25,215.00**	**3,073**	**87.81%**		
SANDWELL & WEST BIRMINGHAM A&E DELIVERY BOARD	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	56,509.00	6,124	89.16%		**90.85%**
	SUMMERFIELD GP SURG & URGENT CARE CENTRE	10,404.00	0		100.00%	
	Total	**66,913.00**	**6,124**	**89.16%**	**100.00%**	
SHEFFIELD A&E DELIVERY BOARD	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	51,218.00	4,613	90.99%		**92.35%**
	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	12,661.00	273	97.84%		
	Total	**63,879.00**	**4,886**	**92.35%**		
SHROPSHIRE A&E DELIVERY BOARD	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	36,147.00	5,917	83.63%		**86.55%**
	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	7,861.00	1		99.99%	
	Total	**44,008.00**	**5,918**	**83.63%**	**99.99%**	

4.3 Operational performance by delivery boards – A&E (8/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
SOMERSET A&E DELIVERY BOARD	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	17,035.00	1,667	90.21%		95.16%
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	11,752.00	852	92.75%		
	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	25,231.00	94		99.63%	
	Total	**54,018.00**	**2,613**	**91.25%**	**99.63%**	
SOUTH NORTHAMPTONSHIRE A&E DELIVERY BOARD	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	29,686.00	2,699	90.91%		90.91%
	Total	**29,686.00**	**2,699**	**90.91%**		
SOUTH TYNESIDE A&E DELIVERY BOARD	SOUTH TYNESIDE NHS FOUNDATION TRUST	17,416.00	1,322	92.41%		92.41%
	Total	**17,416.00**	**1,322**	**92.41%**		
SOUTH WARWICKSHIRE A&E DELIVERY BOARD	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	18,124.00	768	95.76%		95.76%
	Total	**18,124.00**	**768**	**95.76%**		
SOUTH WEST HAMPSHIRE A&E DELIVERY BOARD	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	29,988.00	1,874	93.75%		96.21%
	SOUTHERN HEALTH NHS FOUNDATION TRUST	8,214.00	75		99.09%	
	SOUTHAMPTON NHS TREATMENT CENTRE	13,561.00	13		99.90%	
	Total	**51,763.00**	**1,962**	**93.75%**	**99.60%**	
SOUTHERN DERBYSHIRE A&E DELIVERY BOARD	DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	46,161.00	5,521	88.04%		89.22%
	DERBYSHIRE HEALTH UNITED LTD	5,071.00	0		100.00%	
	Total	**51,232.00**	**5,521**	**88.04%**	**100.00%**	
STOCKPORT A&E DELIVERY BOARD	STOCKPORT NHS FOUNDATION TRUST	24,277.00	5,658	76.69%		76.69%
	Total	**24,277.00**	**5,658**	**76.69%**		
SUNDERLAND A&E DELIVERY BOARD	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	35,711.00	2,034	94.30%		96.01%
	SUNDERLAND GP OUT OF HOURS	18,186.00	118		99.35%	
	Total	**53,897.00**	**2,152**	**94.30%**	**99.35%**	
SURREY AND SUSSEX HEALTHCARE A&E DELIVERY BOARD	SURREY AND SUSSEX HEALTHCARE NHS TRUST	24,286.00	993	95.91%		97.58%
	WEYBRIDGE WALK IN CENTRE	8,151.00	56		99.31%	
	HASLEMERE MINOR INJURIES UNIT	2,247.00	11		99.51%	
	WOKING WALK IN CENTRE	9,854.00	16		99.84%	
	Total	**44,538.00**	**1,076**	**95.91%**	**99.59%**	
SWINDON A&E DELIVERY BOARD	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	37,601.00	4,150	88.96%		90.87%
	CARFAX HEALTH ENTERPRISE	8,109.00	22		99.73%	
	Total	**45,710.00**	**4,172**	**88.96%**	**99.73%**	
TAMESIDE & GLOSSOP A&E DELIVERY BOARD	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	21,518.00	3,013	86.00%		86.00%
	Total	**21,518.00**	**3,013**	**86.00%**		
WALSALL A&E DELIVERY BOARD	WALSALL HEALTHCARE NHS TRUST	29,607.00	4,059	86.29%		90.02%
	WALSALL URGENT CARE CENTRE (COMMUNITY SITE)	11,047.00	0		100.00%	
	Total	**40,654.00**	**4,059**	**86.29%**	**100.00%**	
WANDSWORTH & MERTON EMERGENCY CARE DELIVERY BOARD	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	42,827.00	2,939	93.14%		93.14%
	Total	**42,827.00**	**2,939**	**93.14%**		

4.3 Operational performance by delivery boards – A&E (9/9)

Delivery Board	Org Name	Total AE Attendances	Attendances Over 4 hrs	Performance of providers with a main A&E department (Type1, Type2, Type3)	Performance of all other providers in the patch (Type2, Type3)	Performance for the delivery Board (All Types)
WARWICKSHIRE NORTH A&E DELIVERY BOARD	GEORGE ELIOT HOSPITAL NHS TRUST	19,239.00	1,602	91.67%		**91.67%**
	Total	**19,239.00**	**1,602**	**91.67%**		
WEL LOCAL A&E DELIVERY BOARD	BARTS HEALTH NHS TRUST	116,154.00	12,336	89.38%		**89.38%**
	Total	**116,154.00**	**12,336**	**89.38%**		
WEST CHESHIRE AND WIRRAL A&E DELIVERY BOARD	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	31,047.00	3,426	88.97%		**91.90%**
	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	20,510.00	2,017	90.17%		
	WIRRAL COMMUNITY NHS FOUNDATION TRUST	16,360.00	59		99.64%	
	Total	**67,917.00**	**5,502**	**89.44%**	**99.64%**	
West Essex	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	25,805.00	6,706	74.01%		**74.01%**
	Total	**25,805.00**	**6,706**	**74.01%**		
WEST KENT A&E DELIVERY BOARD	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	43,436.00	5,149	88.15%		**93.32%**
	KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	33,783.00	10		99.97%	
	Total	**77,219.00**	**5,159**	**88.15%**	**99.97%**	
West Norfolk	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	16,586.00	941	94.33%		**94.33%**
	Total	**16,586.00**	**941**	**94.33%**		
WEST SUFFOLK A&E DELIVERY BOARD	WEST SUFFOLK NHS FOUNDATION TRUST	17,425.00	2,187	87.45%		**87.45%**
	Total	**17,425.00**	**2,187**	**87.45%**		
WEST, NORTH AND EAST CUMBRIA A&E DELIVERY BOARD	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	23,783.00	2,366	90.05%		**92.77%**
	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	4,194.00	38		99.09%	
	WORKINGTON HEALTH LIMITED	5,294.00	0		100.00%	
	Total	**33,271.00**	**2,404**	**90.05%**	**99.60%**	
WIGAN BOROUGH SYSTEM RESILIENCE GROUP	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	22,689.00	2,004	91.17%		**91.17%**
	Total	**22,689.00**	**2,004**	**91.17%**		
WILTSHIRE A&E DELIVERY BOARD	SALISBURY NHS FOUNDATION TRUST	13,310.00	1,049	92.12%		**94.20%**
	SALISBURY WALK-IN HC	4,768.00	0		100.00%	
	Total	**18,078.00**	**1,049**	**92.12%**	**100.00%**	
WOLVERHAMPTON A&E DELIVERY BOARD	THE ROYAL WOLVERHAMPTON NHS TRUST	49,611.00	4,743	90.44%		**91.55%**
	WOLVERHAMPTON DOCTORS URGENT CARE	6,978.00	39		99.44%	
	Total	**56,589.00**	**4,782**	**90.44%**	**99.44%**	
WORCESTERSHIRE A&E DELIVERY BOARD	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	48,794.00	7,773	84.07%		**84.77%**
	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	2,239.00	0		100.00%	
	Total	**51,033.00**	**7,773**	**84.07%**	**100.00%**	
YORK AND SCARBOROUGH A&E DELIVERY BOARD	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	51,465.00	4,436	91.38%		**91.38%**
	Total	**51,465.00**	**4,436**	**91.38%**		

5.0 Agency staff costs

5.1 Performance against agency ceiling

Trusts with the lowest agency spending relative to their ceiling - YTD at Q2

Rank	Trust Name
1	North East Ambulance Service NHS FT
2	West Midlands Ambulance Service NHS FT
3	Lincolnshire Community Health Services NHS Trust
4	The Newcastle Upon Tyne Hospitals NHS FT
5	Liverpool Women's NHS FT
6	Royal Surrey County Hospital NHS FT
7	University College London Hospitals NHS FT
8	Birmingham Women's NHS FT
9	Dorset Healthcare University NHS FT
10	Birmingham Children's Hospital NHS FT
11	Cambridge University Hospitals NHS FT
12	The Christie NHS FT
13	Brighton and Sussex University Hospitals NHS Trust
14	Cheshire and Wirral Partnership NHS FT
15	Liverpool Heart and Chest Hospital NHS FT
16	Royal Devon and Exeter NHS FT
17	Gloucestershire Care Services NHS Trust
18	City Hospitals Sunderland NHS FT
19	Sheffield Teaching Hospitals NHS FT
20	Staffordshire and Stoke On Trent Partnership NHS Trust

Trusts with the Highest agency spending relative to their ceiling - YTD at Q2

Rank	Trust Name
237	The Clatterbridge Cancer Centre NHS FT
236	Walsall Healthcare NHS Trust
235	The Dudley Group NHS FT
234	North Middlesex University Hospital NHS Trust
233	Weston Area Health NHS Trust
232	Sussex Partnership NHS FT
231	Kettering General Hospital NHS FT
230	South West Yorkshire Partnership NHS FT
229	Royal Berkshire NHS FT
228	Cornwall Partnership NHS FT
227	Sandwell and West Birmingham Hospitals NHS Trust
226	Manchester Mental Health and Social Care Trust
225	Dartford and Gravesham NHS Trust
224	Mersey Care NHS FT
223	St Helens and Knowsley Hospitals NHS Trust
222	St George's University Hospitals NHS FT
221	Gloucestershire Hospitals NHS FT
220	Great Western Hospitals NHS FT
219	South West London and St George's Mental Health NHS Trust
218	West London Mental Health NHS Trust

5.2 Agency spend as % of total pay

NHS Improvement

Trusts with the lowest agency spend as % of total pay - YTD at Q2

Rank	Trust Name
1	North East Ambulance Service NHS Foundation Trust
2	West Midlands Ambulance Service NHS Foundation Trust
3	The Christie NHS Foundation Trust
4	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
5	East Midlands Ambulance Service NHS Trust
6	Lincolnshire Community Health Services NHS Trust
7	Derbyshire Community Health Services NHS Foundation Trust
8	Liverpool Women's NHS Foundation Trust
9	East Of England Ambulance Serivce NHS Trust
10	Birmingham Children's Hospital NHS Foundation Trust
11	Cambridge University Hospitals NHS Foundation Trust
12	Cheshire and Wirral Partnership NHS Foundation Trust
13	University College London Hospitals NHS Foundation Trust
14	Tees, Esk and Wear Valleys NHS Foundation Trust
15	Birmingham Women's NHS Foundation Trust
16	South Tees Hospitals NHS Foundation Trust
17	City Hospitals Sunderland NHS Foundation Trust
18	Royal Devon and Exeter NHS Foundation Trust
19	Gloucestershire Care Services NHS Trust
20	Royal United Hospitals Bath NHS Foundation Trust

Trusts with the highest agency spend as % of total pay - YTD at Q2

Rank	Trust Name
237	Hounslow and Richmond Community Healthcare NHS Trust
236	Medway NHS Foundation Trust
235	Sherwood Forest Hospitals NHS Foundation Trust
234	Kettering General Hospital NHS Foundation Trust
233	South West London and St George's Mental Health NHS Trust
232	Central London Community Healthcare NHS Trust
231	Manchester Mental Health and Social Care Trust
230	Weston Area Health NHS Trust
229	Colchester Hospital University NHS Foundation Trust
228	West Hertfordshire Hospitals NHS Trust
227	Wye Valley NHS Trust
226	West London Mental Health NHS Trust
225	Milton Keynes Hospital NHS Foundation Trust
224	Surrey and Sussex Healthcare NHS Trust
223	Croydon Health Services NHS Trust
222	North East London NHS Foundation Trust
221	East and North Hertfordshire NHS Trust
220	Calderdale and Huddersfield NHS Foundation Trust
219	George Eliot Hospital NHS Trust
218	Hinchingbrooke Health Care NHS Trust

6.0 End notes and glossary

6.1 End notes

1	All financial information in this report is based on unaudited monitoring returns from 238 licensed NHS trusts and NHS foundation trusts operating as at 31 August 2016. Those licensed providers include 156 NHS foundation trusts (FTs) and 82 NHS Trusts (non-FTs). For foundation trusts authorised during the year, we include their financial data since 1 April 2016 in the foundation trusts' performance.
2	Surplus/(deficit) comparable to control totals are calculated as surplus/(deficit) before impairments, transfers, donated asset income, and donated asset depreciation for all trusts. For non-FTs, IFRIC 12 adjustments are also deducted. For most FTs gains/(losses) on asset disposals are excluded (unless previously agreed)
3	For FTs, the sector reported surplus/(deficit) includes donated asset income, donated asset depreciation t and gains/(losses) on asset disposals (unless previously agreed), as these items have been excluded from the control total an adjustment is needed to add the figures back to provide the reported sector surplus/(deficit). This also includes the NHS trust IFRIC12 adjustment for those trusts gaining FT status in year (NHS trust period
4	As at September 2016, a total of 227 providers have signed up to their control totals.
5	166 trusts reported performance against the A&E target in Q2 2016/17
6	185 trusts reported against RTT incomplete pathway targets in Q2 2016/17. The admitted and non-admitted targets were removed in September 2015.
7	130 trusts reported performance against the breast cancer: 2-week wait target for Q2 2016/17. 155 trusts reported performance against the GP referral: 62-day wait target for Q2 2016/17. 155 trusts reported performance against the all cancers: 2-week wait target for Q2 2016/17.
8	"The aggregate STF improvement trajectories" highlighted for A&E, RTT, Diagnostics and Cancer 62-day waiting time targets are for provider sector only, they differ to the STF improvement trajectories for NHS England.

Glossary (1/2)

A&E	Accident and emergency departments offer a 24-hour, 7-day a week service to assess and treat patients with serious injuries or illnesses.
A&E standard	The objective that any patient attending an A&E department is seen and transferred, admitted or discharged within 4 hours of arrival. The objective performance against this target is 95% of patients. If a trust falls below this performance level, it is deemed to have breached the target.
Ambulance standard	Red 1 calls - these are the most time-critical and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls - these are serious but less immediately time-critical, and cover conditions such as stroke and fits. Cat A calls - the number of Category A calls (Red 1 and Red 2) resulting in an ambulance arriving at the scene of the incident within 19 minutes.
Admitted patient	A patient who is formally admitted to a hospital for treatment. This includes admission that is not overnight, ie day cases.
Cancer waiting-time targets	A series of objective waiting times for patients referred for cancer diagnosis and treatment. Each target has a different objective performance. The waiting times for cancer patients are much stricter than the RTT targets, but the RTT targets include cancer patients.
CCG	Clinical commissioning group
CIP	Cost improvement programme - usually a 5-year planned cost reduction programme to improve the productivity and streamline operational structures to provide efficient, effective services.
Cost weighted activity growth rate	The cost weighted activity is calculated by applying individual cost weights based on average reference costs to elective inpatient, non-elective inpatient, A&E attendance and outpatient attendance activities. This method allows combined cost weighted activity to be derived for different periods, so activity growth based on cost weighted activity could be calculated.
CQC	Care Quality Commission - the independent regulator of health and adult social care services in England that ensures care provided by hospitals, dentists, ambulances, care homes and home care agencies meets government standards of quality and safety.
Day case	A patient who is admitted and treated without staying overnight, eg for day surgery.
DH	Department of Health, the government department responsible for the NHS.
DToC	A delayed transfer of care occurs when a patient is considered ready to leave their current care (acute or non-acute) for home or another form of care but still occupies a bed.
EBITDA	Earnings before interest, tax, depreciation and amortisation. This is an approximate measure of available cash flow. It does not take into account the impact of depreciation, amortisation, financing costs or taxation. This means it can be used to compare performance between organisations that may have very different levels of capital investment and debt financing.
Elective patient	Elective surgery or procedure is scheduled in advance because it does not involve a medical emergency.
High cost drugs	Expensive drugs typically used for specialist treatments, eg cancer, that are excluded from the Payment by Results (PbR) tariff as they would not be fairly reimbursed. Commissioners and providers agree appropriate local prices.
HMT	Her Majesty's Treasury, the government department that fulfils the function of a ministry of finance.

Glossary (2/2)

Keogh	Following the Francis Inquiry, the medical director of NHS England, Sir Bruch Keogh, led a review into the quality of care and treatment provided by 14 hospital trusts in England. His report identified common challenges facing the wider NHS and set ambitions for improvement, which seek to tackle some of the underlying causes of poor care. The report signalled the importance of monitoring mortality statistics to highlight underlying issues around patient care and safety. Using the data to identify trusts that are performing positively will also be helpful in establishing and sharing effective practice across the NHS. The report is available here: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
Non-admitted patient	A patient on a pathway that includes treatment without admission to a hospital; also known as an outpatient.
Non-elective patient	A patient who is admitted for treatment on an unplanned or emergency basis. Such patients are not relevant to referral-to-treatment (waiting-time targets).
Pathway	A patient's journey through an outpatient appointment, diagnostic tests, further outpatient appointments to a potential inpatient appointment (eg for surgery).
PDC dividends	Public dividend capital represents the Department of Health's equity interest in defined public assets across the NHS, including NHS foundation trusts. DH is required to make a return on its net assets, which takes the form of a public dividend capital dividend.
PFI	The private finance initiative is a procurement method that uses private sector capacity and public resources to deliver public sector infrastructure and/or services according to a specification defined by the public sector. In the NHS a typical PFI contract involves a private consortium building a hospital and maintaining it to a defined specification for 20+ years for an NHS trust in return for annual payments from the trust that are indexed to inflation.
PPE	Property, plant and equipment, the term used for fixed assets under International Financial Reporting Standards (IFRS).
SAFER pathway bundle	The 'SAFER' patient flow bundle refers to senior review; all patients will have an expected discharge date and clinical criterial for discharge; flow of patients; early discharge; and review by multidisciplinary team.
Surplus or deficits	Refers to the net financial position. See End notes (Slide 36), as the calculation of this measure differs between the NHS foundation trusts and NHS trusts.
Teaching hospitals	'Teaching' acute trusts are those acute trusts that are members of AUKUH (the Association of UK University Hospitals); a list is available at www.aukuh.org.uk
Waiting times	The time a patient has to wait before treatment; this is termed RTT (referral to treatment) in the NHS.
WTE	Whole-time equivalent is the ratio of the total number of paid hours during a period (part-time, full-time, contracted) by the number of working hours in the period. one WTE is equivalent to one employee working full-time.

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (23 November)**

KEY ITEMS TO NOTE

The Committee noted :

- That the Trust had met its plan in-month, and was £0.5m favourable year to date, and was forecasting to meet the revised planned deficit of £41m, not including Sustainability and Transformation Fund funding.
- The continuing progress achieved by the divisional teams in relation to the financial improvement programme, and the further support of PwC as the Trust embeds new resource to replace this. The month had seen a significant increase in schemes in the 'implement' phase. The cost control trios continued to demonstrate a real contribution to both CIP opportunities and run rate reduction.
- The good benchmark performance in many areas of the Carter plan, and the development of a:
    - hospital pharmacy transformation plan, the focus of which was to enable pharmacists and other pharmacy staff to spend more time on frontline activities, and
    - procurement transformation plan, focused on improving performance on stock turn around and the use of e-invoicing.

The Committee discussed the particularly challenging financial NHS and national environment in which the Trust was required to create a business plan. In preparing the financial plan for 2017/19, the assumptions submitted for the Sustainability and Transformation Plan (STP) had been revisited. Discussions continued with commissioners as to affordability of expected activity levels, and internally as to the appropriate scale of stretching but achievable CIPs. The Committee supported the recommendation from the Executive in that it was not considered possible to submit a draft plan that achieved the proposed control total. It was noted that the draft plan was required to be submitted on 24 November.

Action requested by Trust board

The Trust board is requested to:

- Note the report

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 18 January 2017

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Redevelopment committee report (23 November 2016)**

KEY ITEMS TO NOTE

The Committee noted that the Sellar planning application for the 'cube' building was planned to be discussed at the Westminster council planning meeting on 6 December. The Trust's concerns as to the efficacy and safety of the proposed road would be submitted to Westminster planning.

The Committee noted that discussions continued with Sellar and the Westminster planning office in relation to the potential of sale of Charity buildings to facilitate the Trust's development plans.

The preparation for a planning application for the 'triangle' building (planned to provide a comprehensive outpatient and diagnostic facility for patients) continued; this was expected to be submitted to the Westminster planning office in mid-December.

RECOMMENDATION:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Report from: Sir Richard Sykes, Chairman
Report author: Jan Aps, Trust company secretary
Next meeting: 14 December 2016

Imperial College Healthcare NHS Trust

Report to**: Trust board**

Report from: **Quality Committee (16 November 2016)**

KEY ITEMS TO NOTE

The Chairman welcomed Nick Fox, new Director of Imperial Private Healthcare to his first meeting.

Divisional Director's risk register update: The Committee reviewed the divisional risks:

- Winter planning: the Committee was pleased to note that the winter resilience plan was almost complete which was a key mitigation of the winter planning risk.
- Patients awaiting elective surgery (RTT target): Work continued to address the cohort of patients where the 18 week RTT target had not been achieved. As part of the waiting list improvement programme a data clean-up exercise had been carried out and identified a high volume of patients waiting over 52 weeks for treatment since their referral. In October, the number of patients waiting over 52 weeks was 475. Each of these patients was the subject of a clinical review to make sure that their care plan was appropriate in view of the time they had waited for treatment. The Committee noted that this improvement work should be completed by early 2017.
- Diagnostic equipment: the risk relating to the aging equipment in diagnostic services continued and the Committee noted that two new SPEC CT scanners would be in place early next year which would improve waiting times.
- Lift failures: the Committee noted the work in hand to address the lift failures across the Trust.

CQC quarterly report: The Committee received the quarterly CQC report noting that the Trust would be subject to an announced re-inspection of outpatients and diagnostic imaging on 22 to 24 November. The Committee noted the positive progress being achieved by the outpatient improvement programme.

Quality report: The Committee was pleased to note the positive staff engagement with both the safer surgery programme and the safety culture programme.

Health and safety report: The Committee noted the continuing work to improve compliance with the actions arising from the audit of safer sharps that the Health and Safety Executive (HSE) undertook earlier in the year.

Infection prevention and control report: The Committee received the quarterly report and noted the progress underway to reduce inappropriate antibiotic usage. The Committee were pleased with the decrease in the number of Trust attributed MRSA compared to the previous year's figures.

RECOMMENDATION:

The Trust board is requested to:

- Note the report

Report from: Dr Rodney Eastwood, Chairman, Quality Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: 7 December 2016

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (12 October 2016)**

KEY ITEMS TO NOTE

Internal audit and counter-fraud report: The Committee noted that the audit plan was progressing as planned, with the substitution of an RTT (referral to treatment) validation exercise replacing a couple of smaller reviews. It was also noted that that two of the five counter-fraud open investigations were the subject of criminal proceedings.

Management action plans following audits which had received a limited or no assurance rating: The Committee noted and supported the actions plans being implemented in three areas: the medical equipment management service contract; duty of candour audit compliance; and the serious incident and WHO audit compliance.

Tender waivers, losses and special payments: The Committee were pleased to note the continuing improvement to the position for each of these areas. Work continued to further reduce the financial write-off associated with overseas patients.

Corporate risk register: The Committee was pleased to note the reduction in risk related to delay in reporting diagnostic investigations, and recognised the attention being given to the risk relating to high dependency areas, and the vacancy rate among nursing staff.

Annual review of standing orders and standing financial instructions: The Committee approved the minor changes to the standing orders and standing financial instructions which had been made to reflect organisational changes.

NHS Improvement single oversight framework: The Committee noted the framework and the arrangements in place to ensure the board scorecard and other monitoring processes aligned fully with the new requirements.

RTT and waiting list improvement programme: The committee noted the extensive work underway to deliver RTT performance and to improvement overall waiting list management.

Audit Panel: reported in a separate paper to the Trust board.

Action requested by Trust board
The Trust board is requested to: • Note the report

Report from: Sir Gerald Acher, Chairman, Audit, Risk & Governance Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 7 December 2016