Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC

28 September 2016

11.30 – 13.00

Clarence Wing Boardroom, St Mary's 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 27 July 2016	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 27 July 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 & IC		6
2.4	Month 5 2016/17 Finance report	Chief financial officer		7
2.5	RTT performance: update and recovery plan	DD surgery, cancer & CV		8
3	**Items for decision or approval**			
3.1	NWL sustainability & transformation plan	Chief executive	12.10	9
4	**Items for discussion**			
4.1	CQC update report including OPD inspection preparedness	Director of nursing	12.20	10
4.2	National cancer patient experience results	Director of nursing		11
4.3	Emergency preparedness, resilience & recovery – bi-annual update	Director of nursing		12
4.4	St Mary's Hospital redevelopment – public exhibition	Director of communications		13
5	**Items for information**			
5.1	Single oversight framework	Trust company secretary	12.45	14
5.2	Annual workforce equality report	Director of P&OD		15
6	**Board committee reports**			
6.1	Finance and investment committee (19 August/ 21 Sept)	Committee chair	12.50	16
6.2	Redevelopment committee (27 July/ 21 Sept)	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: 30 November 2016: W12, Hammersmith Hospital – start time to be confirmed – approximately 11.30			

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 27 July 2016
11.15 – 13.00
New boardroom, Charing Cross Hospital

Present:	
Sir Richard Sykes	Chairman
Dr Rodney Eastwood	Non-executive director
Jeremy Isaacs	Non-executive director
Dr Andreas Raffel	Non-executive director
Sir Gerry Acher	Non-executive director
Sarika Patel	Non-executive director
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Dr Julian Redhead	Medical director
Prof Janice Sigsworth	Director of nursing
In attendance:	
Michelle Dixon	Director of communications
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Prof Tim Orchard	Divisional director, medicine & integrated care
Prof Jamil Mayet	Divisional director, surgery, cancer, & CV
Karen Powell	Divisional director of nursing, women's, children's & CS
Peter Goldsbrough	Non-executive director (from 1 September)
Victoria Russell	Designate non-executive director (from 1 September)
Nick Ross	Designate non-executive director (from 1 September)
Prof Jonathan Weber	AHSC director (4.2)
Michael Morton	Chair of PPI strategic lay forum (4.4)
Jan Aps	Trust company secretary (minutes)

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 Prof Sir Anthony Newman Taylor and Prof TG Teoh. He extended a particular welcome to those attendees who had recently been appointed to board positions which would commence on 1 September 2016. The Chairman then reported that both Prof Sir Anthony Newman Taylor and Jeremy Isaacs would be leaving the Trust's board before the next meeting. He extended very warm thanks to them both for the significant contribution and personal commitment that they had both shown to the Trust; they would both be missed. Apologies were noted from Gavin Screaton.	
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 25 May 2016** The minutes were accepted as an accurate record of the meeting.	
1.4	**Record of items discussed at Part II of board meetings held on 25 May 2016 and**	

	1 June 2016 The Trust board noted the report.	
1.5	**Action Log** There were no outstanding actions.	
1.6	**Appointments to the Trust board** The Chairman reported the appointment of the following: • Peter Goldsbrough as non-executive director from 1 September 2016 • Prof Andrew Bush as Imperial College's nominated non-executive director from 1 September 2016 • Nick Ross and Victoria Russell as designate non-executive directors from 1 September 2016. The Trust board noted the appointments, and members agreed to support the induction arrangements as requested.	
1.7	**Trust board and board seminar meeting dates 2017/18** Jan Aps introduced the proposed meeting schedule for 2017/18, noting that similar timings were planned for Trust board and board seminar meetings, and a return to bi-monthly meetings for quality committee; the timing for finance and investment committee meetings remained open to discussion to optimise the availability of current financial information. The Trust board agreed to the proposed dates for: • Trust board meetings, and board seminars • Quality committee • Audit, risk and governance committee (noting that further change may be required once accounts submission dates are confirmed) • Remuneration committee. Finance and investment committee and redevelopment committee would be subject to further discussion and agreed by chairman's action.	
2	**Operational items**	
2.1	**Chief Executive's report** Dr Tracey Batten introduced her report, particularly noting: • Commencement of refurbishment of outpatient areas at Charing Cross Hospital, and plans for similar areas at Hammersmith and Western Hospitals, which was being funded by the Charity. • The second phase of the restructuring had been completed with clinical directors, senior nurses and general managers appointed. • A health and safety executive (HSE) visit to assess the Trust's management of risk of blood borne viruses from sharps injuries had resulted in the issuing of two improvement notices; work progressed to address issues raised. The HSE had stated that they recognised the considerable amount of work that had been undertaken to improve the overall handling of sharps across the Trust. • The full business case for Shaping a Healthier Future (SaHF) was planned to be submitted, via approval at the Trust and CCG boards, to NHS England, in September 2016. There was a potential opportunity to bring forward phase 1 of St Mary's redevelopment; the Trust and Charity were engaging with a developer who may be interested in purchasing some buildings owned by the Charity. This could enable 40 separate outpatient and diagnostic departments to be brought together to provide a far improved patient experience. Public engagement would be held in September with a planning application proposed for October 2016. • Having been discussed at various times since 2009, the Royal Brompton Hospital and Royal Marsden FTs had formally become partners in the Imperial Academic Health Sciences Centre (AHSC); this would provide significant opportunities to align research, education and clinical services. • West London Mental Health Trust had now joined with the Trust, Hammersmith &	

	Fulham GP Federation and the Chelsea & Westminster Hospital FT in exploring the development of accountable care partnerships which would deliver more responsive and more proactive care across communities. Such developments would align with the Sustainability and Transformation Plan (STP). • The establishment of North West London Pathology, to provide pathology services, using a hub and spoke configuration with the Trust as the host, across much of north west London had been granted approval by NHS Improvement. The Trust board noted the chief executive's report.	
2.2	**Integrated performance report** SAFE / EFFECTIVE: In commenting on the safety and effectiveness indicators, Dr Julian Redhead particularly noted that serious incidents were now being reported earlier, with de-escalation at a later date where appropriate; this was felt to align with the Trust's good reporting and low harm culture. He reported that there had also been one never event; urgent review of all post-operative count mechanisms was in hand. There had been a small increase in the number of C difficile cases; actions to bring this back in line were being undertaken. The Trust had received very positive feedback following recent Health Education England visits. CARING: Prof Janice Sigsworth noted that the friends and family test (FFT) results remained slightly confusing; A&E patients were generally satisfied, maternity patients had high expectations of the service; and outpatient responses needed to be improved (national evidence demonstrated that the higher the response rate, the higher the satisfaction). WELL LED: David Wells noted that vacancy rates remained a challenge in nursing and midwifery, but that clear strategies to address these issues were in place; sickness rates remained low; and appraisal completion rates appeared slightly low, but this was due to the bulk of appraisals being carried out during this period. Mr Wells would provide further information in relation to the bank and agency target and current performance. RESPONSIVE: Prof Jamil Mayet confirmed that his team were focusing on improving the position vis-à-vis the referral to treatment times (RTT), particularly in addressing those patients who had been found to have been waiting in excess of 52 weeks. Sarika Patel expressed concern that, having worked so hard to achieve a good RTT position, the Trust appeared to have lost ground. Prof Mayet also noted that pressure on bed availability remained high in summer, and the division were piloting new ways of reducing elective cancellations. Prof Tim Orchard, recognising the poor performance against the target in recent months, reported that a recovery trajectory had now been agreed, and was being met. Responding to Sir Richard Sykes concerns that initiatives introduced in 2014/15 appeared not to have found traction, he noted that issues existed at both the 'front end' and 'back end' of the hospital; discharging patients to a more appropriate environment continued to be a challenge, and patient numbers continued to rise year on year. It was hoped that working more closely with commissioners, it would be possible to improve the offer in the community, and to encourage use of alternate facilities. Highlighting the award of the urgent care centre (UCC) at St Mary's to Vocare, Prof Orchard noted that initial clinical issues had been addressed, but that performance remained behind plan; concerns were raised with the commissioners. Karen Powell reported that diagnostic targets were being achieved, and further work was being done to reduce the number of patients who did not attend their outpatient appointments. Responding to a query from Nick Ross, Kevin Jarrold confirmed that the Trust was capturing email addresses in order to reduce the number of hard copy letters requiring to be sent to patient's, and hopefully improve attendance. The Trust board noted the operational report.	
2.3	**Month 3 2016/17 Finance report** Richard Alexander reported that, at the end of quarter one, the Trust was reporting a	

	deficit of £15.14m, a favourable variance to plan of £0.23m. He commented that this demonstrated the hard work of and financial control by teams during the first three months, but confirmed that the Trust was not complacent about the scale of the challenge in the months ahead. Mr Alexander also reported that whilst the Trust had not been place in special financial measures, it had been listed as one of the 13 trusts not having accepted the proposed control total. The Trust board noted the finance report.	
3	**Items for decision or approval**	
3.1	**Corporate risk register** Prof Janice Sigsworth introduced the register which consisted of a total of 17 risks (eleven operational, six strategic) with a risk score ranging from 12 to 20, noting that it had been subject to thorough review at executive level and the audit, risk and governance committee. She outlined the changes which had been made since the previous review by the Trust board in November 2016. Responding to a query from Jeremy Isaacs, Kevin Jarrold reported that a new post had been created which would lead on cyber security; this had been the subject of a discussion at the audit, risk and governance committee. Sir Gerry Acher expressed concern at the worsening risk score in relation to staff engagement, and sought reassurance this was being appropriately addressed. Responding, David Wells outlined that the staff engagement survey had been relaunched to all staff, supported by external expertise, and a range of further interventions were being developed. Agreeing with Nick Ross's comments that engagement was about how colleagues treated each other, Mr Wells noted that his support and help in this area would be appreciated. The Trust board noted the changes made to the register and accepted the corporate risk register as an accurate reflection of the key risks faced by the Trust.	
3.2	**Board assurance framework** Jan Aps presented the paper, which, as a new approach to the board assurance framework, sought to demonstrate the way in which the Trust provided assurance from its reporting arrangements rather than an approach taking assurance from the direct control of its risks. The paper proposed a fifth strategic objective, *To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance',* which sought to address the breadth of the well-led and use of resources priorities, given the growing Trust and national focus on these areas. In discussion, confirmation was given that the appropriate balance in reporting existed between accountability and assurance. Sir Gerry Acher commented that the framework was a clear step forward in clarity and a key part of the armoury of the board. The Trust board approved the revised board assurance framework, and agreed that it would be presented at six-monthly intervals. The proposed fifth strategic objective was also approved.	
3.3	**Annual complaints report** Prof Janice Sigsworth introduced the paper and reported the improvements brought about following the changes which were made to the complaints function during 2015/16. Improvements included a more responsive nature of responding to concerns, and a significant reduction in the time taken to respond to written complaints, with all complaints now responded to within the timescale agreed with the complainant. It was noted that the highest number of complaints related to outpatient appointment delays and cancellations; this was being addressed as part of the outpatient improvement programme. Prof Sigsworth also reported a reduction in the number of cases investigated by the Ombudsman. Discussing complaints relating to patient transport it was noted that the Trust would focus considerable effort into the re-tendering of the service, including considering	

	which services should be provided by the Trust and which by the commissioners, and what vehicles were required; a paper would be presented to the quality committee during the pre-tender stage, and the committee would oversee service improvement. Non-executive directors challenged whether the criteria for such was comprehensively applied. The Trust board welcomed the improvements reported and approved the report for publishing on the Trust website.	
3.4	**Acute medicine & Chest pain proposals – feedback from engagement** Noting that the service change proposals had previously been presented to the Trust board at its May meeting, Prof Tim Orchard reported back on the five week engagement process. He highlighted that feedback had recognised the improvements that would be delivered to patients, and had been supportive and encouraging; questions and requests for further information had been addressed. The Trust board welcomed the positive engagement response, and approved the phased implementation of the proposed changes to the chest pain and acute medicine pathways.	
4	**Items for discussion**	
4.1	**NWL sustainability & transformation plan** Dr Batten introduced the paper which outlined the 'place-based' five year plan build around the needs of the local population and which supported the implementation of NHS England's five year forward view. The local plan had been developed across the eight boroughs and commissioning groups, and acute, mental health and community services providers, and set out a shared ambition across partner organisations to create an integrated health and care system. (£4m in paragraph three should read £4bn). In discussion, Dr Batten commented that the Sustainability and Transformation Plan (STP) articulated what needed to be in place prior to service reconfiguration: she confirmed that major service changes at Charing Cross currently sat outside the timescale of the STP (which would be a five year plan). The Trust board noted the STP as submitted and gave approval to proceed with the five year plan as proposed.	
4.2	**AHSC Annual report 2015/16** Prof Jonathan Weber introduced the annual report, noting that it had been presented to and approved by the joint executive group, and submitted to the Department of Health. A lay summary of the report would be made available on the Trust website. The report demonstrated progress against objectives themes and work programmes originally agreed in the 2013 AHSC application. In noting the report, the Trust board extended thanks to Prof Weber and his team for its informative and helpful nature.	
4.3	**Improving the quality of care - CQC update** Prof Janice Sigsworth introduced the paper, highlighting the following items: • The CQC five-year regulatory strategy had been publicised which introduced an annual review process more focused on self-assessment against the five domains and use of 'Intelligent Monitoring' to develop a shared view of the quality of services. • The CQC would be inspecting the outpatient and diagnostic imaging services across the Trust's three main sites on 22-24 November; work was in hand to prepare for the inspection. • Divisional self-assessments against the CQC domains continued in the divisions, a toolkit to support this process would be complete by August 2016. The Trust board noted the report.	
4.4	**Patient and public engagement strategy**	

	Michelle Dixon highlighted the importance of including patients and the public in development of the Trust's services, and introduced Michael Morton as the chair of the strategic lay forum. He outlined the establishment and development of the forum, and its engagement both in the overall direction of travel of patient and public engagement, and direct involvement of individual members in the proposed changes to acute medicine and chest pain pathways and the phase 1 redevelopment of St Mary's Hospital. Mr Morton noted the Trust's commitment to engaging with local people, but recognised that some proposals will never receive universal support. The Trust board approved the strategy.	
5	**Board committee reports**	
	The Trust board noted the reports from the board committees as follows: • Audit, risk & governance committee (6 July) • Quality committee (15 June / 13 July) • Finance and investment committee (20 July) • Redevelopment committee (29 June).	
6	**Items for information**	
	There were no items for information.	
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: • It was recognised that the national availability of capital funds had reduced significantly, at the same time as additional pressure was being placed on Trusts to meet control totals due to the national financial position; this may impact the Trust's development plans. • The financial improvement programme support being provided by PwC (approved by the Trust's regulator) had been budgeted at £1.5m, to support the Trust in delivering its savings target of £54m, and to identify further productivity improvements. • It was recognised that the membership of the strategic lay forum had been, to an extent, focused on those already engaged with the Trust or partner bodies. In future, membership would be offered to a wider population. • It was confirmed that, irrespective of an individual local authority's commitment to the STP, any health programmes or pathways developed would be introduced comprehensively across the STP population. • Recognising that the proposed junior doctors' contract was to be nationally imposed, the medical director noted that there had been close and supportive working throughout the junior doctors' industrial action, and embedded and positive relationships had been built which would be helpful in implementing future service developments.	
9	**Date of next meeting**	
	Annual General Meeting: 14 September 2016, St Paul's Church, Queen Caroline Street, Hammersmith, London W6 9PJ Private/Public Trust board: 28 September 2016: Clarence Wing board room, St Mary's Hospital Seminar & development session: 10.00 on 26 October 2016, W12, Hammersmith Hospital	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 September 2016

Record of items discussed at the confidential Trust board meetings on 27 July 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 27 July 2016:

Westminster sexual health services tender
Particularly noting the inter-relationship with other services, the Trust board gave approval in principle to the submission of a bid, in partnership with Chelsea & Westminster NHS FT, to supply genito-urinary medical services to the tri-borough area from April 2017. The service was being tendered for a five-year period, and the service specification was changed from the existing service, which would require the service delivery to be changed.

Estates strategy
The Trust board approved the estates strategy 2016/26, which reviewed the current position (giving particular attention to backlog maintenance), the future vision (to support delivery of the clinical strategy) and options for the route between these two.

Recommendation 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.

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)

MATTERS ARISING

Minute Number	Action /issue	Responsible	September 2016 Update
27 July 2016 Question from the public	To explain Bank and Agency metric and performance trend	David Wells	This is the combined Bank and Agency spend as percentage of the total Paybill. This Key performance indicator (KPI) is part of the broader suite of workforce KPIs referenced in the monthly Performance Scorecard, please note it is not a Quality metric and NHSI are focused on the Agency spend where we have a target to reduce from £51m total agency spend in 2015/16, to be reduced to £34m in 2016/17 (which we are currently on target to achieve). The 2016/17 target for this measure is a Trust set target and reflects the annual percentage value submitted to NHS Improvement within the Trusts 16/17 Operating Plan for this particular KPI of 9.12%. Month 3 performance against this measure was 12.32%, seen as 6.35% for bank (£3.16m) and 5.97% for agency (£2.97m). Last financial year we spent more on Agency than Bank, so this is a very positive change. Spending more on bank is driving our position over the 9.12% target - approximately £1m more bank spend in June 2016 than in June 2015.

Imperial College Healthcare NHS Trust

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	28 Sept 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 around a patient with learning disabilities and multiple health problems, having recently been diagnosed with bowel cancer, and how collaborative working and staff demonstrating kindness resulted in a good outcome for a good quality experience for the patient.

Quality impact:

The board will hear how staff adopting innovative approaches to care results in improved patient care and outcomes This activity is relevant to the safe and caring CQC domains.

Financial impact:

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

Risk impact:

None

Recommendation(s) to the Committee:

The 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.

Author	Responsible executive director	Date submitted
Guy Young, Deputy Director of Patient Experience	Janice Sigsworth, Director of Nursing	21 September 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.

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.
- To illustrate the personal and emotional sequelae of a failure to deliver quality services, for example following a serious incident

The Board has previously been made aware that a key area for development is the quality of care provided to patients with learning disability and this is a priority work stream for the patient experience team in 2016. The story the board will hear provides an example of when things work well; a standard which we aim to meet all the time. Collaborative working and our people demonstrating kindness is pivotal to providing a high standard of care to this vulnerable group of patients.

2. W's story

This month's patient story focuses around W, a 54 year old man with multiple health problems and learning disabilities. W is currently receiving respite care in a nursing home following the formation of a stoma in July 2016. W's story will be told by his home manager, Angela, who has worked intensively with W during this difficult period. W will be present.

The theme is how the trust worked with W and his home manager to meet W's additional needs and support him through a surgical procedure; subsequent appointments.

In August 2016, the inclusion & vulnerability officer (IVO) at ICHT was informed by W's social worker that he would be returning as a day case for the removal of his indwelling vena cava filter. He was accompanied by Angela. The IVO facilitated reasonable adjustments being implemented including showing W the environment in which the procedure would happen and liaising with the consultant to arrange for either the home manager or IVO to accompany W into the procedure room if needed.

The staff that met W were kind with 'smiling faces', the phlebotomist remembered that W could not have bloods taken from his left arm and the portering staff were friendly and attentive. The stoma nurse has provided excellent support for W in learning about his stoma. She has been helpful and friendly, making time for W.

Back on the ward (Riverside ward), W was greeted by his nurse's 'beaming smile', he was well cared for and returned to the care home that evening with a copy of his discharge letter. On his way home, W sat and smiled and said it had been a 'very good day, everyone had been kind'.

The outpatient appointment the following week was an excellent example of how staff

behaviour positively impacted on W's experience. He was accompanied by Angela and met by the IVO. Staff helped W to register at the check-in kiosk. He had an early appointment and was taken straight to a quiet area to wait.

His consultant explained to W the results of the tests and why further surgery would not be possible. He was attentive and sympathetic and used simple words and phrases that helped W understand. The appointment was not rushed and the consultant made sure that W had understood everything before they left.

This story illustrates that our staff are becoming much more aware and engaged in caring for those with learning disabilities and that through working in close collaboration, exhibiting the trust values in all we do, we can have a positive impact for our patients.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	28 September 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:

1) Financial performance
2) The Trust's financial improvement programme
3) Operational performance
4) Stakeholder engagement
5) BBC2 documentary
6) Update on major building improvements
7) Junior Doctor contract and proposed industrial action
8) Recommendations of the Health and Safety Executive (HSE) inspections
9) CQC re-inspection of Outpatients and Diagnostic Imaging
10) Acute Medicine and Chest Pain pathway changes
11) Other key strategic issues

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, Chief Executive	Tracey Batten, Chief Executive	21/09/16

Chief Executive's report

Key Strategic Priorities

1. Financial performance

For August 2016 the Trust reported an in-month deficit of £6.94m which is slightly better than the planned deficit of £6.95M. Year-to-date (i.e. to end August 2016) the Trust reported a deficit of £24.71m, £0.49m better than our plan.

This represents a great achievement by all our staff in helping to meet a challenging financial plan. However there is much more to do to ensure we achieve, and ideally exceed, our year-end plan.

2. Financial improvement programme

As reported in the July Chief Executive's report, the Trust continues to work in partnership with management consultants, PwC, to progress our financial improvement programme. Phase 2 of the Financial Improvement Programme involves 13 weeks of PwC support up to October 2016. They have supported the Trust in establishing a Project Support Office (PSO) which is driving efficiencies in the long-term and improving cost management at an organisational level overall.

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 September Trust board agenda states that the cost improvement plan programme is behind plan by £3.3m as of the end of August 2016. The Trust is working closely with PwC 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 July 2016 the Trust achieved six of the eight national cancer standards. The Trust underperformed against the 62-day GP referral to first treatment standard and a CCG-agreed plan is in place, addressing issues with urology and gastrointestinal diagnostic pathways. The Trust is expecting to deliver planned performance from August 2016. Underperformance on the 62-day screening standard was through patient choice and unavoidable, complex pathway delays. There was no Trust-initiated cause of the delays within the reported breaches.

Accident and Emergency: Performance against the four hour access standard for patients attending Accident and Emergency was 90.8 per cent in August 2016, meeting the performance trajectory target for the month of 90.1 per cent. The Trust continues to work closely with partners across the local health system on the recovery plan and actions are on track.

Referral to treatment (RTT): The performance for August 2016 was 83.3 per cent (July performance was 84.6 per cent) against a standard of 92 per cent of patients being treated within 18 weeks of referral. We have established a waiting list improvement team and action plan, with external expert advice and support, to ensure we return to delivering the RTT standard sustainably. Please see the separate paper on the September Trust board agenda for further detail.

Diagnostic waiting times: In August 2016, 0.82 per cent of patients were waiting over six weeks against a tolerance of 1 per cent.

4. Stakeholder engagement

We have continued our regular programme of stakeholder engagement. In September, 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.

The Trust's strategic lay forum also met in September to further develop patient and public involvement at the Trust.

Engagement on the proposed phase one redevelopment of St Mary's Hospital has continued this month with a three-day public exhibition held on the 8 to 10 September. Please refer to the separate item on the public exhibition and proposed plans for the phase one redevelopment on the September Trust Board agenda.

Our 2015/16 Annual General Meeting was held on Wednesday 14 September at St Paul's Church in Hammersmith.

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

5. BBC Two Documentary

Following nearly a year of development, filming for a new television documentary series is scheduled to take place from Monday 10 October 2016 to Friday 27 November 2016 across all Trust sites. The six-part documentary for BBC Two will show how we are responding to the challenges and opportunities we face as an NHS Trust in 2016, operationally and strategically. The series is expected to air in January 2017.

The senior leadership of the production company behind the series, Label 1, have a solid track record, having previously commissioned and/or produced other NHS documentaries, including 24 hours in A&E, One Born Every Minute and An Hour to Save Your Life.

Reflecting our normal policy, only individuals who wish to be involved will be filmed. It is being made absolutely clear to our patients that their decision to be involved or not will have no impact on their care or waiting time. We have drawn up a detailed consent and filming protocol, built with learning from other trusts, to ensure that patient safety, care and experience continue to always come first.

We have had a very positive response from patients, staff and many of our partners who are supportive of the Trust's participation in the documentary.

6. Update on major building improvements

<u>Lift Upgrade Programme</u>

In view of the on-going problems with many of the lifts across the Trust (there are 114 in total) the Trust is currently investing approximately £3.85m in a programme to upgrade a number of them. To date 16 lifts have been identified for repair in the first two years, in Queen Elizabeth Queen Mother building and the Lindo Wing at St Mary's Hospital and in the tower/laboratory block at Charing Cross Hospital.

During the upgrade work, we are ensuring patients and visitors are fully informed about the lift works and get the support they need to reach their destination.

Refurbishment of St Mary's Emergency Department

As reported in the July 2016 Chief Executive Report, the programme of works to refurbish the Emergency Department (ED) at St Mary's Hospital started in June and is due to be completed by March 2017. The work has been commissioned in recognition that the current layout and design of the department at St Mary's Hospital no longer meets the demands of the service.

The refurbishment is being funded by Imperial College Healthcare Charity. The ED will remain open and operational throughout the refurbishment, although capacity will be reduced during some phases of the work. Patients will be kept up to date with this work and how it may impact on them, as it progresses.

Refurbishment of Main Outpatients and the new Central Booking Office

Work is underway to refurbish main Outpatients at Charing Cross Hospital, starting with the ENT, Audiology and Ophthalmology clinic areas which will re-open in December 2016. In addition, work continues to open a new Central Booking Office on the Charing Cross site which will open later this year to streamline patient administration across the Trust. Work is also scheduled for main and renal outpatients at Hammersmith Hospital.

The refurbishment is being funded by Imperial College Healthcare Charity. Planning for improvements at outpatients at the Western Eye Hospital is underway with further funding from the Charity.

Refurbishment of Riverside Theatres

Work is underway to refurbish the Riverside Theatres on the Charing Cross Hospital site. These Theatres are for patients requiring a 'day surgery' procedure and so, typically, will go home on the same day as their operation. The aim of this project is to improve the way the Theatre space is used to make it more efficient and to allow for better patient experience both before and after their day surgery.

We are fortunate that the refurbishment is, again, being funded by Imperial College Healthcare Charity.

7. Junior Doctor Contract and Proposed Industrial Action

The British Medical Association's proposed junior doctors' industrial action, in response to the introduction of the new junior doctors' contract, due to take place from 12-16 September, was called off by the BMA due to patient safety concerns. The Trust will continue to work positively with our junior doctors and wider workforce to plan effectively for the proposed industrial action currently scheduled for October, November and December.

8. Recommendations of the Health and Safety Executive (HSE) inspections

As reported in the July 2016 Chief Executive's Report, the HSE visited the Trust as part of its national inspection programme in June to assess how we are identifying and managing the risks of exposure to employees from blood borne viruses as a consequence of sharps injuries. At the time of the inspection the HSE acknowledged recent progress the Trust had made in this area, but initial feedback highlighted a number of areas that required improvement. The Trust received formal written feedback from the HSE on 22 July which has informed a detailed action plan to ensure all recommendations are acted on and fully implemented by 18 October. The five areas for action are as follows:

- Using safer sharps (instead of non-safe sharps)

HSE has served an improvement notice, specifically relating to the use of medical sharps in paediatric services.

- Information, instruction and training on sharps

HSE requires the Trust to ensure employees receive adequate information, instruction and training regarding sharps.

- Vaccinations (immunisations)

HSE requires the Trust to ensure all staff that should be vaccinated, are vaccinated. An Immunisations task and finish group has been set up to oversee the changes required.

- Incident investigation

HSE requires the Trust to ensure root causes are identified, lessons are learned and investigation findings are used, where appropriate, to change practice.

- Accident reporting

The HSE requires the Trust to ensure that all incidents involving sharps injuries are being reported promptly and without delay, through Datix (the Trust's reporting system for incidents)

In August 2016, the HSE also visited St Mary's Hospital to audit the Trust's management of the risk of legionella arising from its use of a cooling tower. The HSE found two areas requiring action and the Trust was required to respond with an action plan to address these issues by 23 September 2016. The two items requiring attention were as follows:

- The Trust is required to take suitable action to remedy some corrosion found in the plant of the cooling tower.
- The Trust is required to ensure that its written scheme of plant operation and maintenance is kept updated and reviewed regularly.

The Trust has now addressed both issues and is working on a better long term solution where we will replace the cooling towers at St Mary's with refrigeration equipment.

9. CQC re-inspection of Outpatients and Diagnostic Imaging

The CQC has notified the Trust that it will re-inspect our Outpatient and Diagnostic Imaging services between 22 and 24 November 2016. This follows the CQC Trust inspection in September 2014 where Outpatients was rated as 'inadequate' across the St Mary's, Charing Cross and Hammersmith Hospital sites. The Trust's Outpatient Improvement Programme continues to make good progress against the CQC recommendations made in 2014 and we look forward to this re-inspection later in the year to demonstrate the progress we have made.

10. Acute Medicine and Chest Pain Pathway Changes

Following a period of engagement with patients, commissioners and other local stakeholders, and subsequent Board approval in July, we have implemented our proposals to improve acute medicine and chest pain patient pathways. This includes:

-
- Consolidating acute medicine services at St Mary's and Charing Cross hospitals, .
- A new streamlined pathway at Hammersmith Hospital for chest pain patients, including for those who would previously have been first admitted to St Mary's or Charing Cross hospitals.
- Refurbishment of the heart assessment centre at Hammersmith Hospital to improve the patient experience and expand capacity.
- A new, 24 hour, specialist renal and haematology triage unit on Fraser Gamble ward

at Hammersmith Hospital to speed up diagnosis and onward care plans.

This is a very important and positive change to ensure patients get the right care in the right place at the right time.

Key Strategic Issues

1. St Mary's Hospital redevelopment plans

Please refer to the separate paper on the September Trust board agenda.

2. National Institute for Health Research Biomedical Research Centre competition, 2016

The Department of Health has announced the results of the 2016 NIHR Biomedical Research Centre competition. Imperial has been awarded £90m over five years from April 2017.

In partnership with Imperial College Healthcare NHS Trust, Imperial College Academic Health Science Centre (AHSC) has received £90m for research to develop and improve treatments for patients.

The Biomedical Research Centre (BRC) award, from the National Institute for Health Research (NIHR), was announced today and will cover five years from April 2017. The NIHR is funded by the UK Department of Health.
The NIHR Imperial BRC was first established in 2007 and this new funding will allow the BRC to continue its world-class research into cancer, heart disease, brain sciences, immunology, infection, surgery and metabolic disorders.

It will also support cross-cutting research and technology development in areas such as genomics, imaging, molecular phenotyping and the use and storage of biomedical data and samples. In addition, for the first time, the NIHR award to the Imperial BRC will fund research into gut health, with a focus on innovative approaches to disease that consider the microbiome.

The work funded by the NIHR Imperial BRC is already having an impact on how patients are diagnosed and treated. For example, researchers have developed a promising potential treatment for the childhood degenerative disease Friedrich's ataxia. They have also created a new test for a form of kidney disease, and generated new insights into cardiovascular disease using imaging technology and genomics. Furthermore, researchers have designed a prototype implantable chip that can help control appetite, and an intelligent surgical knife called the "iKnife", which can tell a surgeon if the tissue that they are cutting into is cancerous.

Professor Alice Gast, President of Imperial College London, said: "We are proud to receive this BRC award as it shows how important our work is. We have talented people pursuing research at the forefront of medical science that makes a real difference to patients. We will invest these new resources into internationally excellent medical research in areas from infection to genomics, and from gut health to surgery. Imperial researchers are at the leading edge of discoveries in healthcare, and developing them into new treatments for patients across the world."

The funded research will build on the close partnership between the College and Imperial College Healthcare NHS Trust, to ensure new discoveries in biomedical science are pulled

through as quickly as possible into clinical practice for the benefit of patients. Imperial College London and Imperial College Healthcare NHS Trust are founding members of the first Academic Science Health Centre (AHSC), which aims to improve the quality of life of patients by taking research discoveries and translating them into new therapies as quickly as possible.

Imperial College Healthcare NHS Trust chief executive, Dr Tracey Batten said: "This is fantastic news for our Academic Health Science Centre (AHSC) and is a reflection of the outstanding research work undertaken by our staff across a wide range of specialties including cancer, cardiovascular and brain science, to name a few.

“Working together the Trust and College have long been at the forefront of cutting edge research and finding innovative ways to translate scientific breakthroughs into better treatments and models of care for our patients so that they receive the best care possible. This funding will allow us to continue being a world leader in research and medical innovation.”

Professor Jonathan Weber, Director of the Imperial BRC and Vice Dean of Research in the Faculty of Medicine at Imperial said: “As the Imperial BRC Director, I am delighted by the continuing and high level of support by NIHR for our translational research. This award particularly reflects the close and productive relationship between all of our College Faculties and the BRC in the pull-through of Imperial discovery science into the clinic. We will now use our new award to bring together our technological platforms for imaging, genomics, molecular phenotyping and informatics - and to enhance our capacity for the analysis of healthcare data, with the Imperial Data Science Institute.”

Professor the Lord Ara Darzi of Denham, Director of the Institute for Global Health Innovation at Imperial College London, theme lead for surgery and technology in the NIHR Imperial BRC, and Honorary Consultant Surgeon at Imperial College Hospital NHS Trust said: “In my long career as a surgeon and a scientist, I have seen the difference new technologies and innovations make to patients’ lives. The BRC strengthens our ability to translate major scientific discovery and innovation into impactful improvements in patient care. With this new funding we can continue this valuable work.”

3. North West London Sustainability and Transformation Plan

Please refer to the separate paper on the September Trust board agenda.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**28 September 2016**

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of August 2016 (month 5).

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

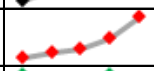
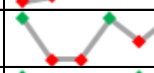
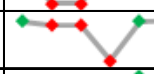
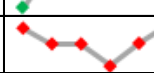
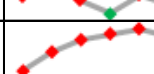
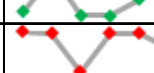
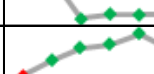
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director
Terence Lacey (Performance Support Business Partner) Ruth Holland (Deputy Chief Information Officer)	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

Scorecard summary

Key indicator	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Aug-16	-	**16**	
Incidents causing severe harm (number)	Julian Redhead	Aug-16	-	**0**	
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Aug-16	-	**0.04%**	
Incidents causing extreme harm (number)	Julian Redhead	Aug-16	-	**0**	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Aug-16	-	**0.01%**	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Aug-16	44.0	**43.5**	
Never events (number)	Julian Redhead	Aug-16	0	**0**	
MRSA (number)	Julian Redhead	Aug-16	0	**0**	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Aug-16	23	**32**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Aug-16	95.0%	**95.8%**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Aug-16	-	**5**	
Staffing fill rates (%)	Janice Sigsworth	Aug-16	tbc	**97.3%**	
Post Partum Haemorrhage 1.5L (PPH) %	Janice Sigsworth	Aug-16	2.80%	**2.2%**	
Core training - excluding doctors in training / trust grades (%)	David Wells	Aug-16	90.0%	**86.4%**	
Core training - doctors in training / trust grades (%)	David Wells	Aug-16	90.0%	**56.9%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Aug-16	0	**1**	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Apr-16	100	**62.01**	
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Qtr 4 15/16	90.0%	**92.2%**	
Caring					
Friends and Family Test: **Inpatient** service % patients recommended	Janice Sigsworth	Aug-16	95.0%	**96.7%**	
Friends and Family Test: **A&E** service % recommended	Janice Sigsworth	Aug-16	85.0%	**96.9%**	
Friends and Family Test: **Maternity** service % recommended	Janice Sigsworth	Aug-16	95.0%	**95.0%**	
Friends and Family Test: **Outpatient** service	Janice Sigsworth	Aug-16	94.0%	**89.4%**	
Well Led					
Vacancy rate (%)	David Wells	Aug-16	10.0%	**11.6%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Aug-16	10.0%	**10.5%**	
Sickness absence (%)	David Wells	Aug-16	3.1%	**2.7%**	
Bank and agency spend (%)	David Wells	Aug-16	9.2%	**12.0%**	
Personal development reviews (%)	David Wells	Aug-16	95.0%	**51.2%**	
Non-training grade doctor appraisal rate (%)	Julian Redhead	Aug-16	95.0%	**74.1%**	
Staff FFT (% recommended as a place to work)	David Wells	Q1		**53%**	
Staff FFT (% recommended as a place for treatment)	David Wells	Q1		**75%**	
Education open actions (number)	Julian Redhead	Aug-16	-	**59**	

Key indicator	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Responsive					
RTT: 18 Weeks Incomplete (%)	Jamil Mayet	Aug-16	92.0%	**83.3%**	
RTT: 18 weeks Incomplete breaches - number of patients waiting	Jamil Mayet	Aug-16	-	**10,028**	
RTT: Number of patients waiting 52 weeks or more	Jamil Mayet	Aug-16	0	**102**	
Cancer: 2-week GP referral to 1st outpatient - cancer (%)	Jamil Mayet	Jul-16	93.0%	**93.2%**	
Cancer: Two week GP referral to 1st outpatient – breast symptoms (%)	Jamil Mayet	Jul-16	93.0%	**93.5%**	
Cancer: 31 day wait from diagnosis to first treatment (%)	Jamil Mayet	Jul-16	96.0%	**97.3%**	
Cancer: 31 day second or subsequent treatment (surgery) (%)	Jamil Mayet	Jul-16	94.0%	**100.0%**	
Cancer: 31 day second or subsequent treatment (drug) (%)	Jamil Mayet	Jul-16	98.0%	**100.0%**	
Cancer: 31 day second or subsequent treatment (radiotherapy) (%)	Jamil Mayet	Jul-16	94.0%	**100.0%**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Jamil Mayet	Jul-16	85.0%	**80.9%**	
Cancer: 62 day urgent GP referral to treatment from screening (%)	Jamil Mayet	Jul-16	90.0%	**86.0%**	
Cancelled operations (as % of elective activity)	Jamil Mayet	Aug-16	0.8%	**0.9%**	
28 day rebooking breaches (% of cancellations)	Jamil Mayet	Aug-16	5.0%	**9.6%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Aug-16	95.0%	**77.9%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Aug-16	95.0%	**90.8%**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Aug-16	1.0%	**0.8%**	
Outpatient Did Not Attend rate %: (First & Follow-Up)	Tg Teoh	Aug-16	11.0%	**11.9%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Aug-16	10.0%	**8.2%**	
Antenatal booking 12 weeks and 6 days excluding late referrals (%)	Tg Teoh	Aug-16	95.0%	**96.0%**	
Complaints: Total number received from our patients	Janice Sigsworth	Aug-16	100	**110**	
Complaints: % responded to within timeframe	Janice Sigsworth	Aug-16	95%	**99.0%**	
Money and Resources					
In month variance to plan (£m)	Richard Alexander	Aug-16		**0.01**	
YTD variance to plan (£m)	Richard Alexander	Aug-16		**0.49**	
Annual forecast variance to plan (£m)	Richard Alexander	Aug-16		**0.00**	
Agency staffing (% YTD)	Richard Alexander	Aug-16	1.0%	**5.1%**	
YTD NHS income performance variance to plan (£m)	Richard Alexander	Aug-16		**6.41**	
CIP % delivery YTD	Richard Alexander	Aug-16		**82.0%**	

1. Key indicator overviews

1.1 Safe

1.1.1 Safe: Serious Incidents

Sixteen serious incidents (SIs) were reported in August 2016. We continue to declare SIs as soon as the incident is reported. The Trust harm profile remains low.

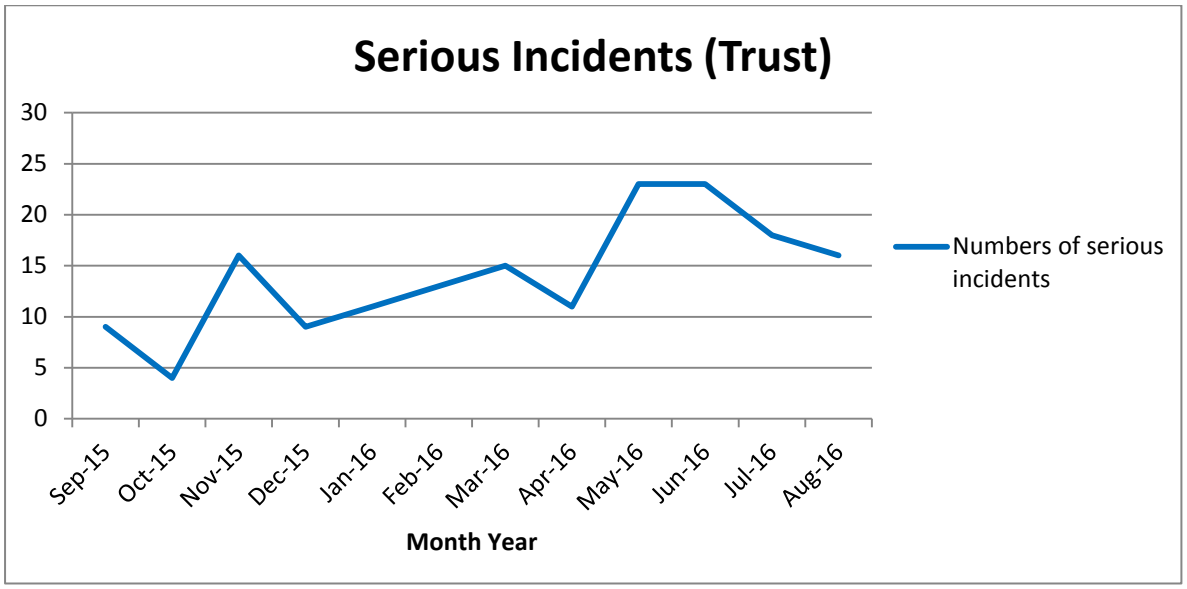


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period September 2015 – August 2016

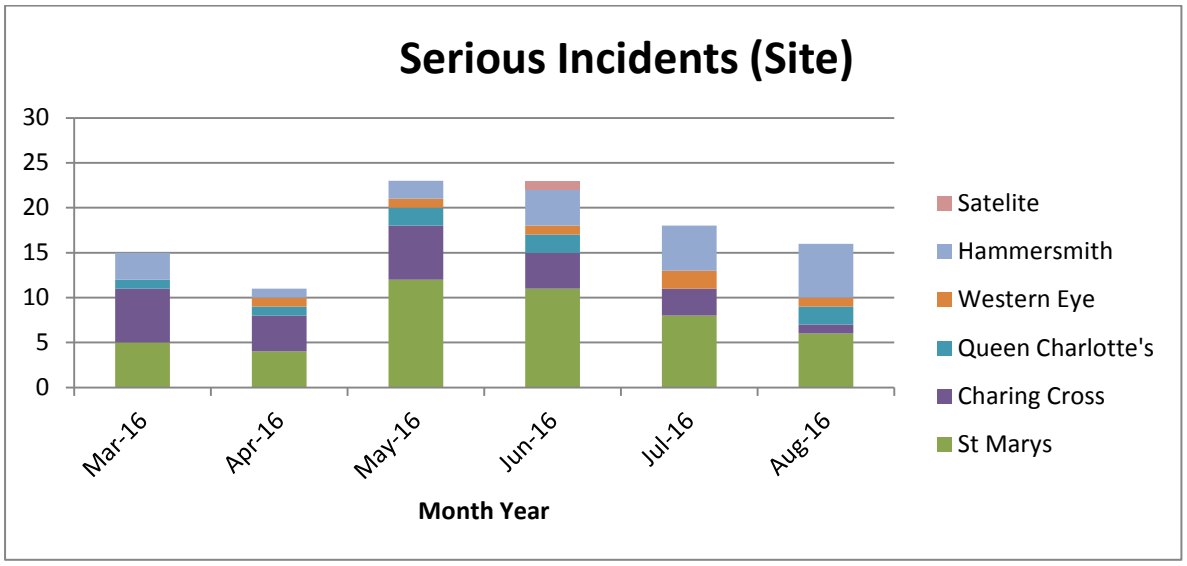


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period March 2016 – August 2016

1.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust did not report any incidents causing major/severe harm or extreme harm/death during August 2016.

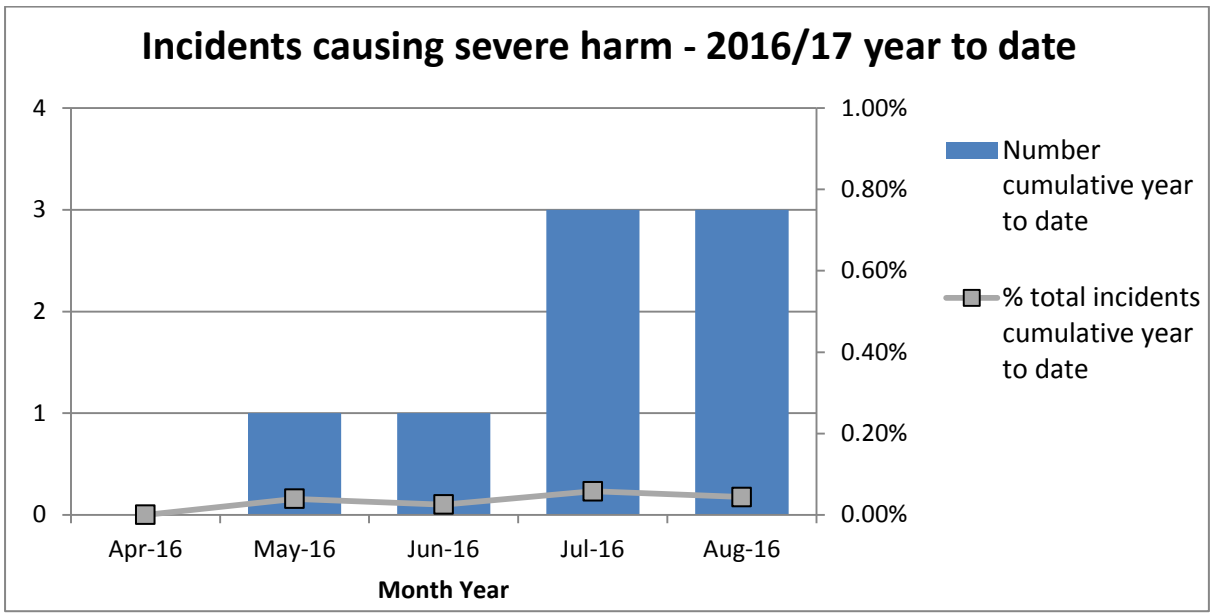


Figure 3 – Incidents causing severe harm by month from the period April 2016 – August 2016 (numbers YTD and as % of total patient safety incidents YTD)

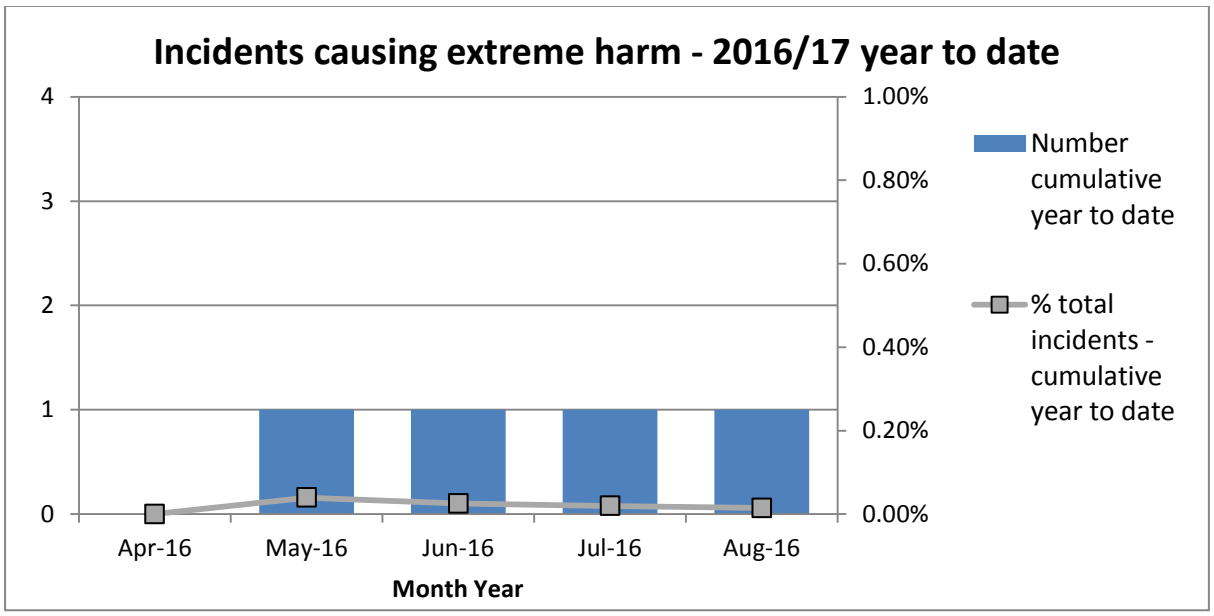


Figure 4 – Incidents causing extreme harm by month from the period April 2016 – August 2016 (numbers YTD and as % of total patient safety incidents YTD)

Patient safety incident reporting rate

The Trust's patient safety incident reporting rate is 43.5 for August 2016 which is just below the top quartile. The rate typically fluctuates monthly.

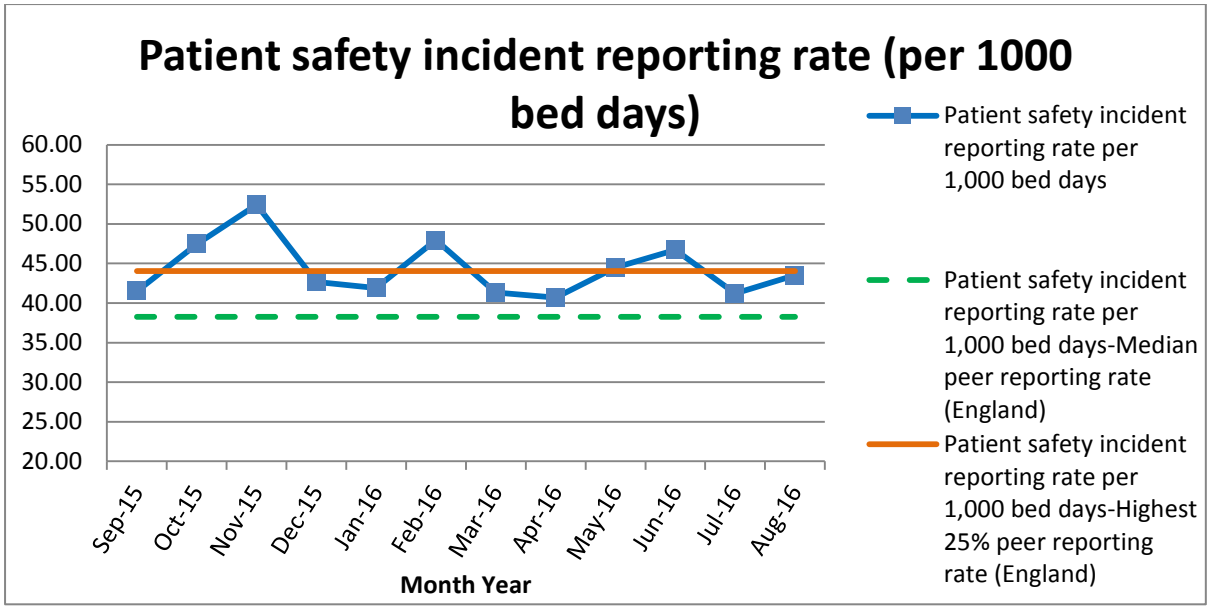


Figure 5 – Trust incident reporting rate by month for the period September 2015 – August 2016

(1) Median reporting rate for Acute non specialist organisations (NRLS 01/04/2015 to 30/09/2015)

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

Never Events

There were no never events reported by the Trust in August 2016. The never event reported in March 2016 has been downgraded to a serious incident following agreement with the commissioners that it did not meet the never event criteria.

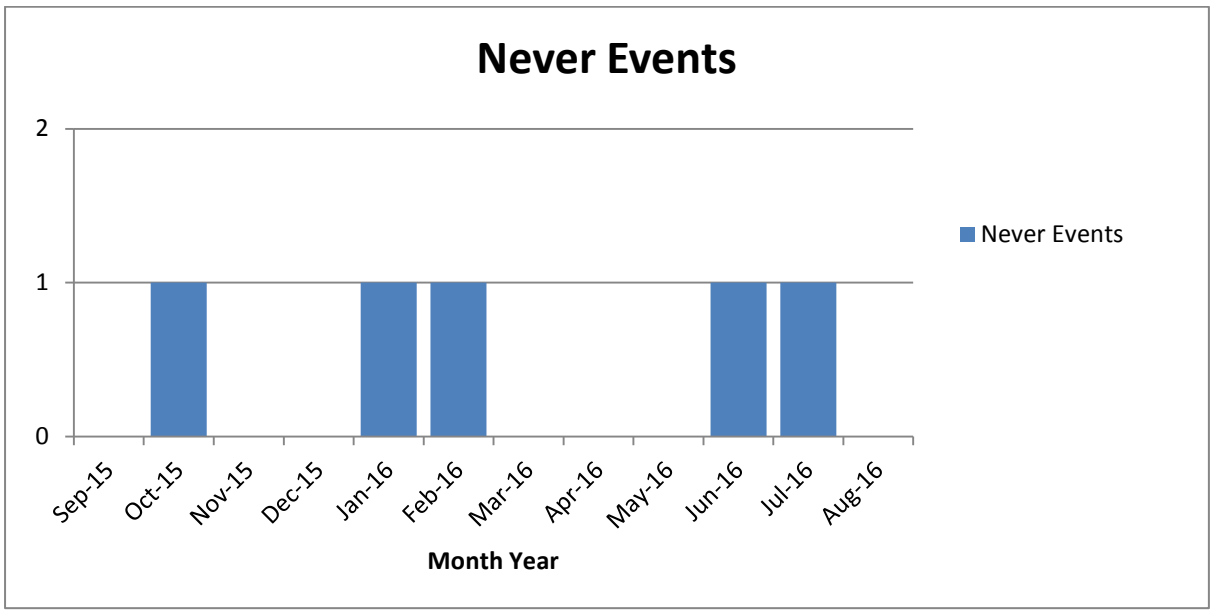


Figure 6 – Trust Never Events by month for the period September 2015 – August 2016

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

Five cases of MRSA BSI have been identified at the Trust in 2016/17; only one case has been allocated to the Trust which was in May 2016.

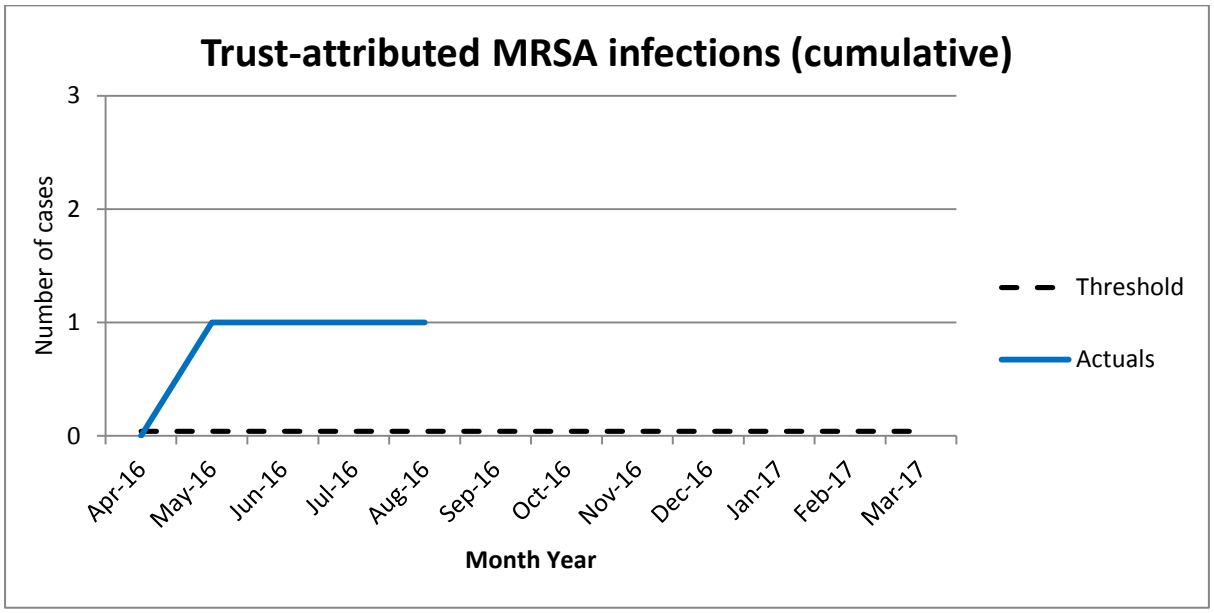


Figure 7 – Cumulative number of MRSA infections for the period April 2016 – March 2017

1.1.4 Safe: Clostridium difficile

Eight cases of *Clostridium difficile* were allocated to the Trust for August 2016.

The locations of these cases are shown below:

- CXH: Ward 6 West (Division of Surgery, Cancer & Cardiovascular)
- SMH: Medical HDU, Samuel Lane and two on Manvers Ward (Division of Medicine and Integrated Care)
- HH: Peters Ward, Christopher Booth Ward and Kerr Ward (Division of Medicine and Integrated Care)

Two of these cases have been identified as a potential lapse in care, one on Medical HDU and one on Samuel Lane. Both related to cross-transmission of the same ribotype.

A total of 32 cases have been allocated to the Trust in 2016/17 which is above the year to date threshold, the annual threshold is 69 cases.

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 now reviewed through the Trust quality and safety sub-group.

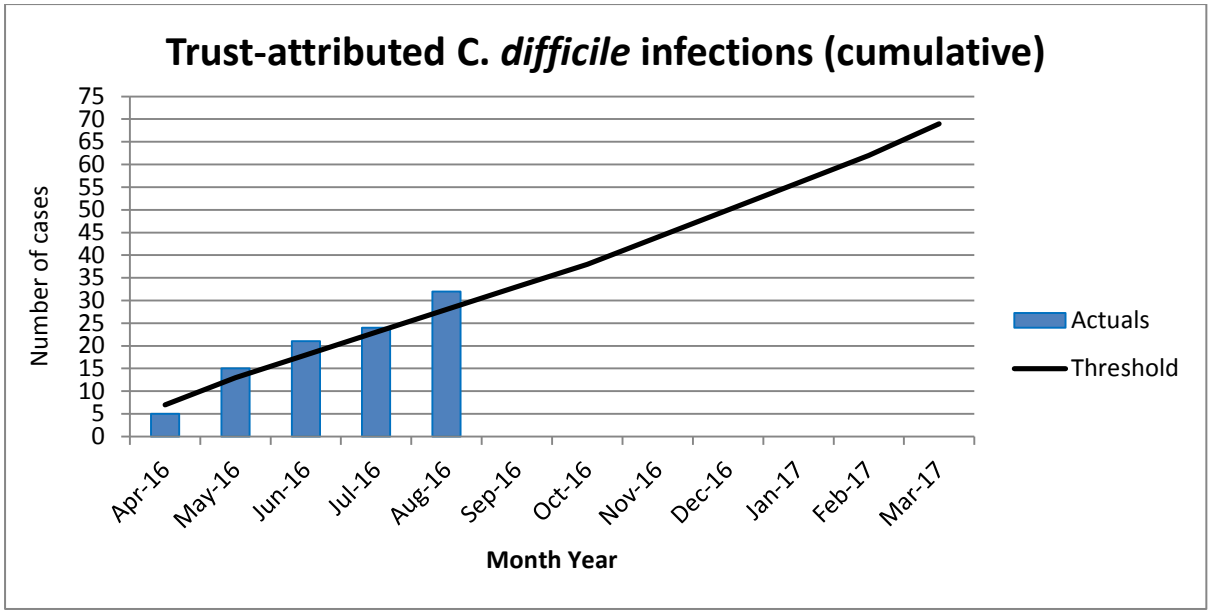


Figure 8 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2016 – March 2017

1.1.5 Safe: Venous thromboembolism (VTE) risk assessment

In August 2016, 95.81 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.

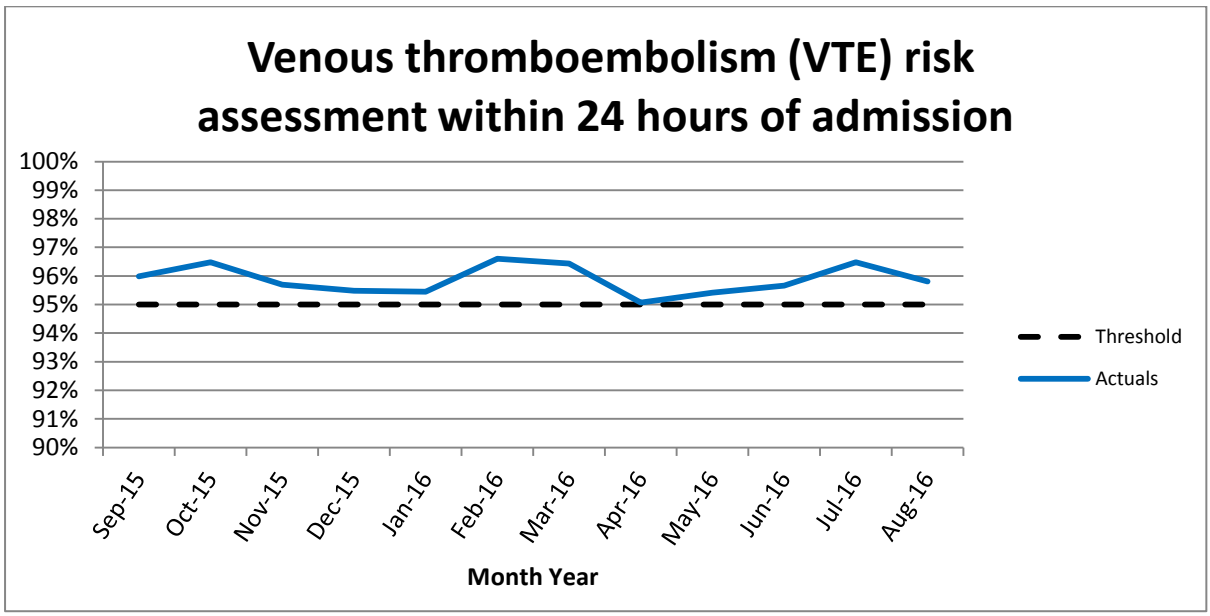


Figure 9 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period September 2015 – August 2016

1.1.6 Safe: Avoidable pressure ulcers

There were 5 avoidable pressure ulcers reported in August 2016 (defined as trust-acquired category 3, 4 and unstageable). A total of 11 have been reported in 2016/17. The target is for a 10 per cent reduction on 2016/17 which equates to no more than 22. The Trust has not reported a grade 4 trust acquired pressure ulcer since March 2013.

All pressure ulcers are reported as a serious incident and investigated by the Senior Nurse for the clinical area and local actions plans implemented.

A new Trust pressure ulcer policy will be launched on 'Stop Pressure Ulcer Day' on the 17 November 2016. Pressure ulcer prevention is a mandatory e-learning requirement for Nurses, Midwives and healthcare assistants. The Tissue Viability team continue to work closely with all of the wards to ensure prevention of pressure ulcers is a priority.

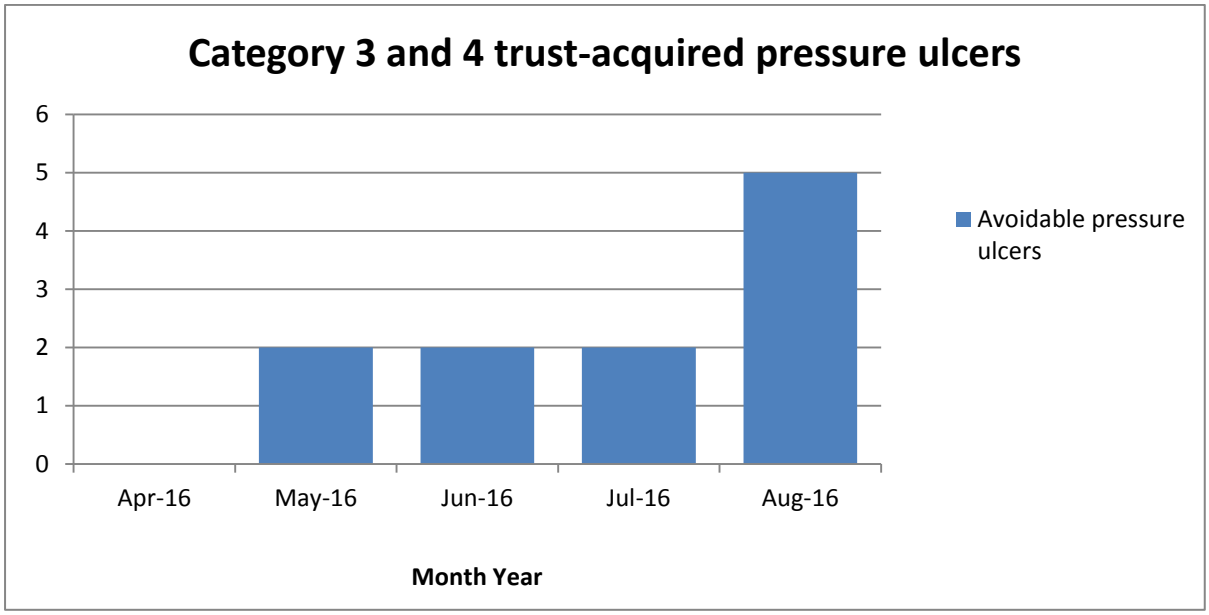


Figure 10 – Number of category 3 and category 4 (including unstageable) trust-acquired pressure ulcers by month for the period April 2016 – August 2016

1.1.7 Safe: Postpartum haemorrhage

In August 2016, 17 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 2.2 per cent of deliveries and meets the NW London target which is for no more than 2.8 per cent of women to have a PPH.

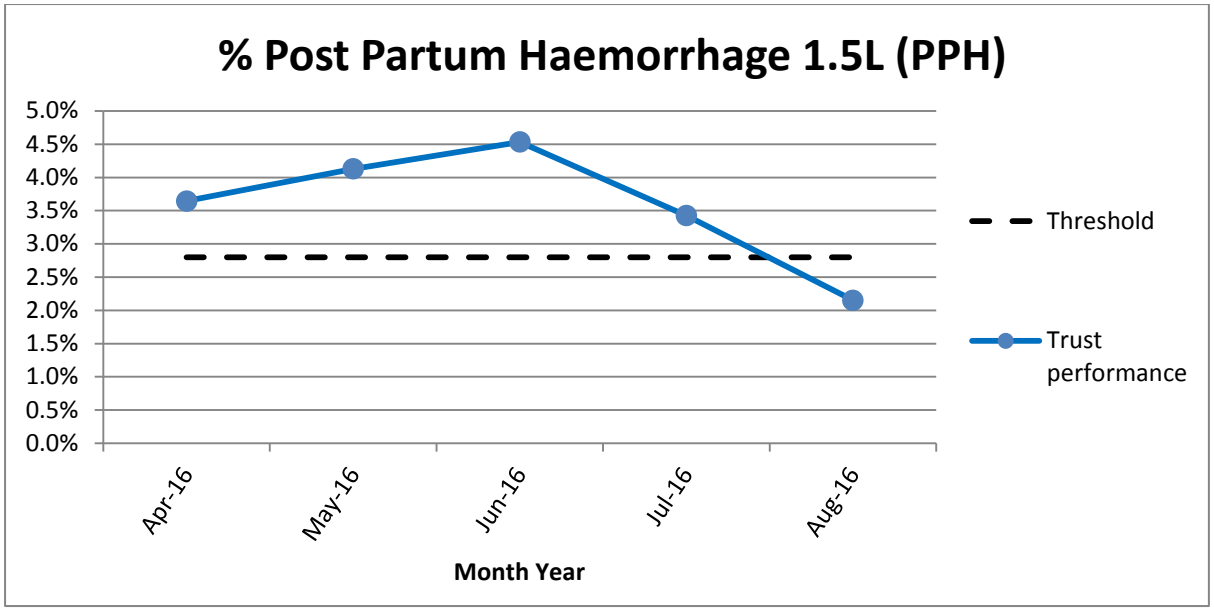


Figure 11 – Postpartum haemorrhage (PPH) for the period April 2016 – August 2016

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

In August 2016 the Trust met safe staffing levels overall. The thresholds are 90 per cent for registered nurses and midwives and 85 per cent for care staff. The percentage 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	97.33%	95.16%	97.34%	98.76%
Hammersmith	96.06%	95.68%	99.42%	98.46%
Queen Charlotte's	96.36%	99.25%	97.86%	97.40%
St. Mary's	97.13%	94.50%	97.52%	97.83%

The fill rate was below 85 per cent for care staff and 90 per cent for registered nurses (RNs) for the following wards.

- 7 North (general surgery) had a fill rate of 84.76 per cent for day shifts, which was 13 shifts unfilled mainly as a result of difficulty in filling the healthcare assistant (HCA) shifts through bank. The overall fill rate was 92 per cent.
- 6 South (oncology) had a night fill rate of 75.29 per cent for RNs and 81.58 per cent fill rate for RNs overall. This reflected a deliberate reduction in staffing in response to reduced clinical activity during the month of August.
- Valentine Ellis Ward (trauma and orthopaedics) had a fill rate of 81.61 per cent during the day for care staff and an overall fill rate of 91.76 per cent for care staff. This equates to 13 unfilled shifts that were required for patients requiring one to one care.
- Western Ward (clinical haematology) had a fill rate of 81 per cent for care staff

at night and this equates to two shifts unfilled.

- In the division of surgery, cancer and cardiovascular sciences Ward C8 had a day fill rate of 76.92 per cent for RNs, a day fill rate of 80 per cent for care staff with an overall day fill rate of 77.78 per cent. This was due to reduced activity and bed base within the area requiring a deliberate reduction of the original planned staffing numbers.
- Riverside ward had a night fill rate of 89.04 percent for RNs . This gap reflects a change in the establishment that is not yet reflected in the e-rostering template and as such there were no unfilled shifts.

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.

Ward sisters and matrons covered unfilled shifts for enhanced care in the divison of surgery,cancer and cardiovascular sciences. In addition, the Divisional Directors of Nursing regularly review staffing requirements including patient feedback.

There is continued difficulty in filling HCA shifts at the Hammersmith site and this is being addressed by the nurse bank.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in August 2016 were safe and appropriate for the clinical case mix.

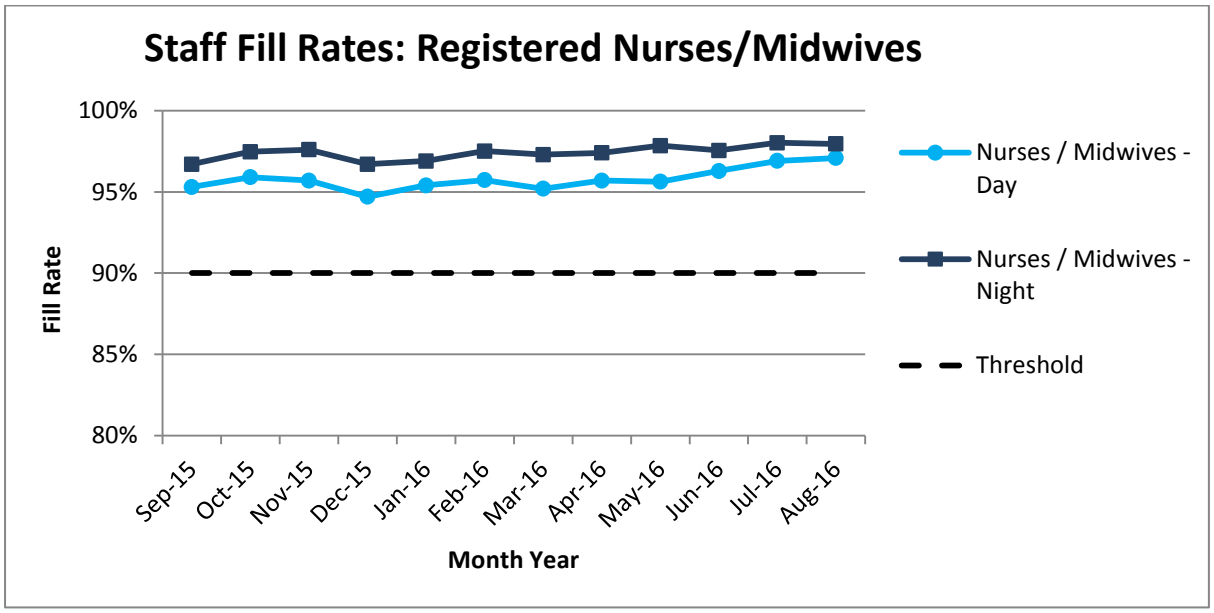


Figure 12 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period September 2015 – August 2016

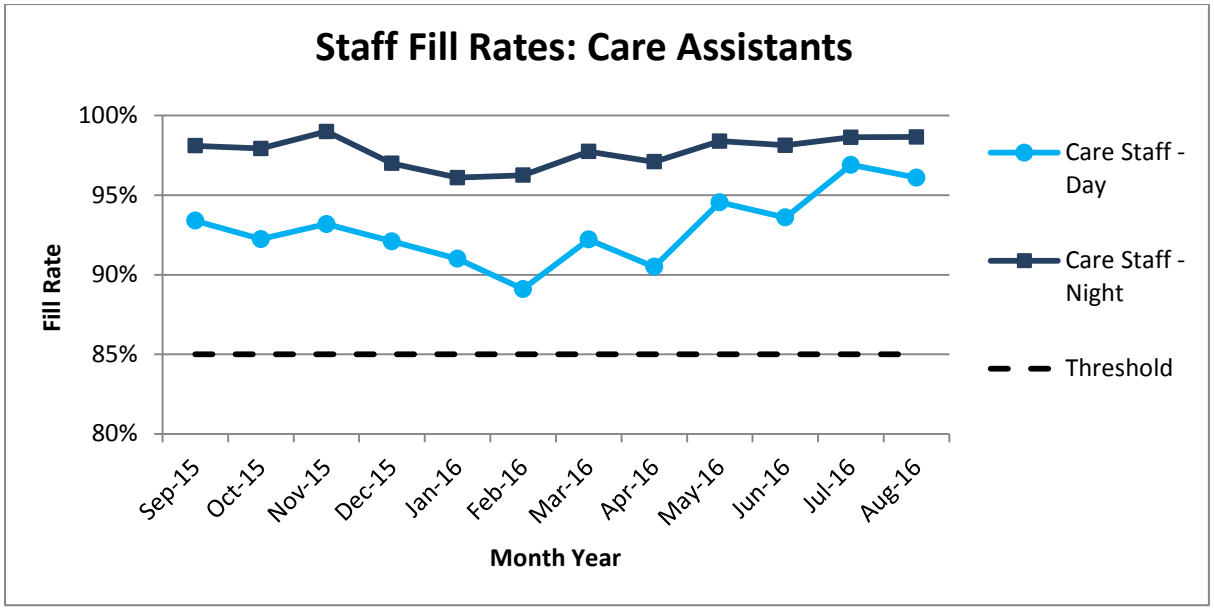


Figure 13 - Monthly staff fill rates (Care Assistants) by month for the period September 2015 – August 2016

1.1.9 Safe: Statutory and mandatory training

Core skills - excluding doctors in training / trust grade

In August 2016, overall compliance was 86.36 per cent against the target of 90 per cent or more. Work continues to improve compliance in the departments where performance is below target, and particular focus is on the topics of Fire Safety for Clinical and High Risk staff, and Resuscitation as part of the Core 10 topics all staff are required to complete.

Core Skills for doctors in training / trust grade

In August 2016, overall compliance was 56.88 per cent against the target of 90 per cent or more. This reflects the current compliance of the new intake of doctors in August/September. Action is underway to identify how we can improve on the number of training records that can be transferred from other Trusts on transfer and action now is focused completing e-learning modules for those that did not transfer records.

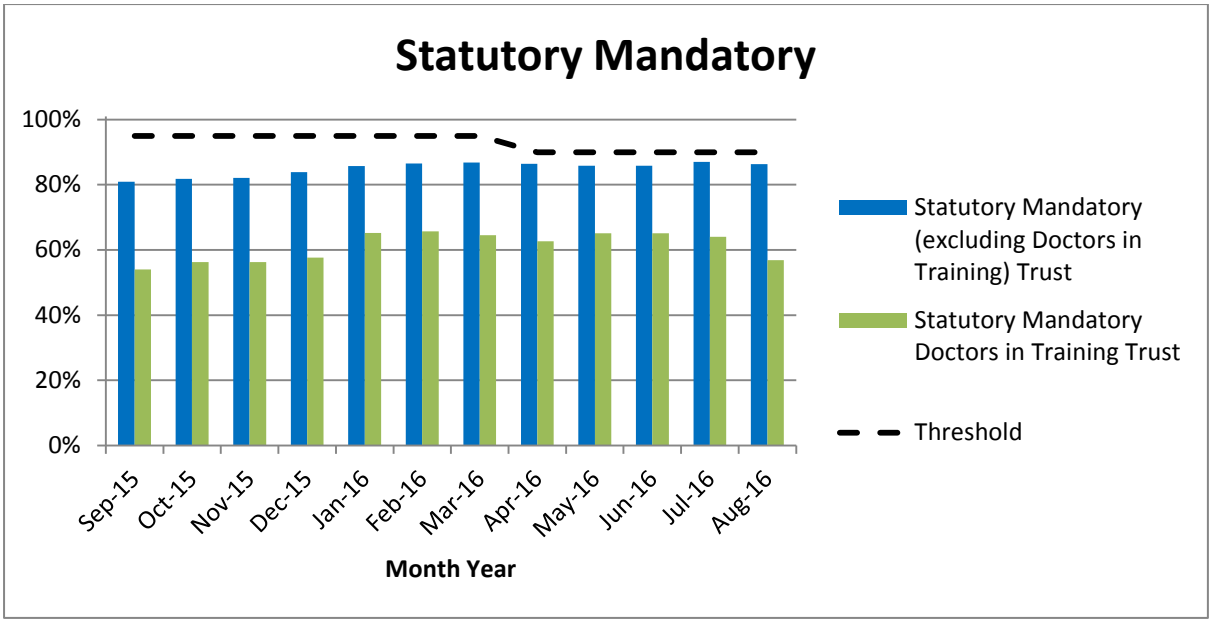


Figure 14 - Statutory and mandatory training for the period September 2015 – August 2016

1.1.10 Safe: Work-related reportable accidents and incidents

There were two RIDDOR-reportable incidents (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) in August 2016.

- The first incident was a staff slip, trip and fall, resulting in a work-related sickness absence of over 7 days
- The second incident was a staff 'collision' (person struck their head on a cupboard), resulting in the person being taken to A&E where they lost consciousness

In the 12 months to 31st August 2016, there have been 35 RIDDOR reportable incidents of which 13 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.

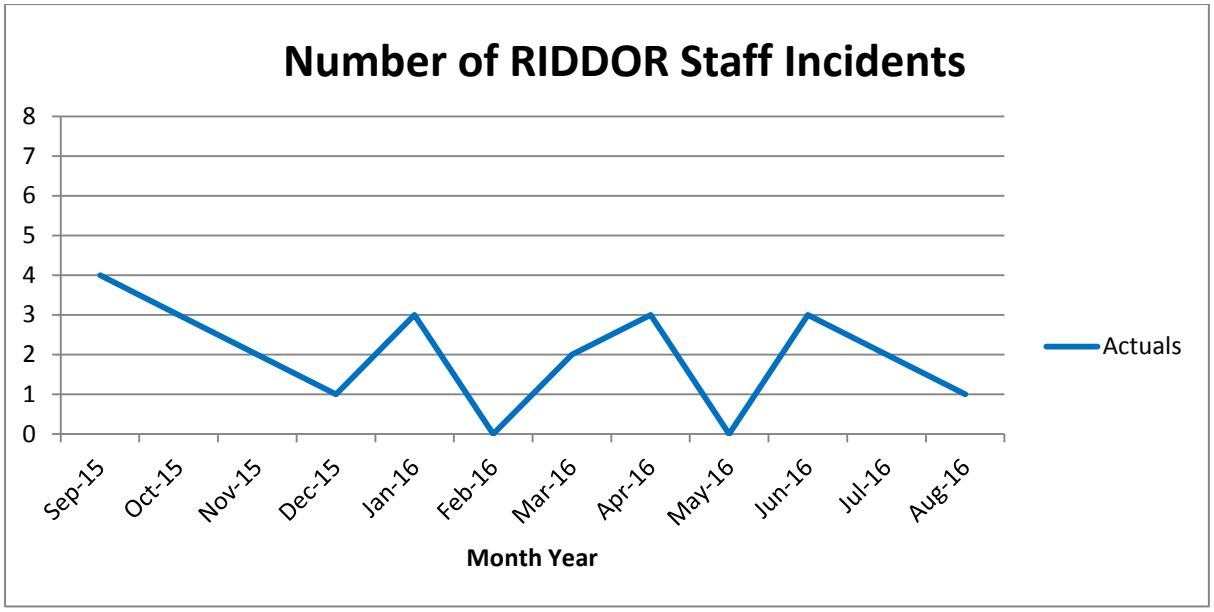


Figure 15 – RIDDOR Staff Incidents for the period September 2015 – August 2016

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.

The reports of 19 national clinical audits in which the Trust participated have been published between April 2016 and August 2016; these are being reviewed by the clinical divisions. Actions and recommendations arising from the audit reports will be monitored through the clinical audit & effectiveness group, the first meeting of which is taking place on 30th September 2016. The results will be reported to executive quality committee in the quality report.

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 62.01 for April 2016. Across the last year of available data (May 2015 – April 2016), the Trust has the third lowest HSMR for acute non-specialist trusts nationally. The Trust has the third lowest SHMI of all non-specialist providers in England for Q4 2014/15 to Q3 2015/16.

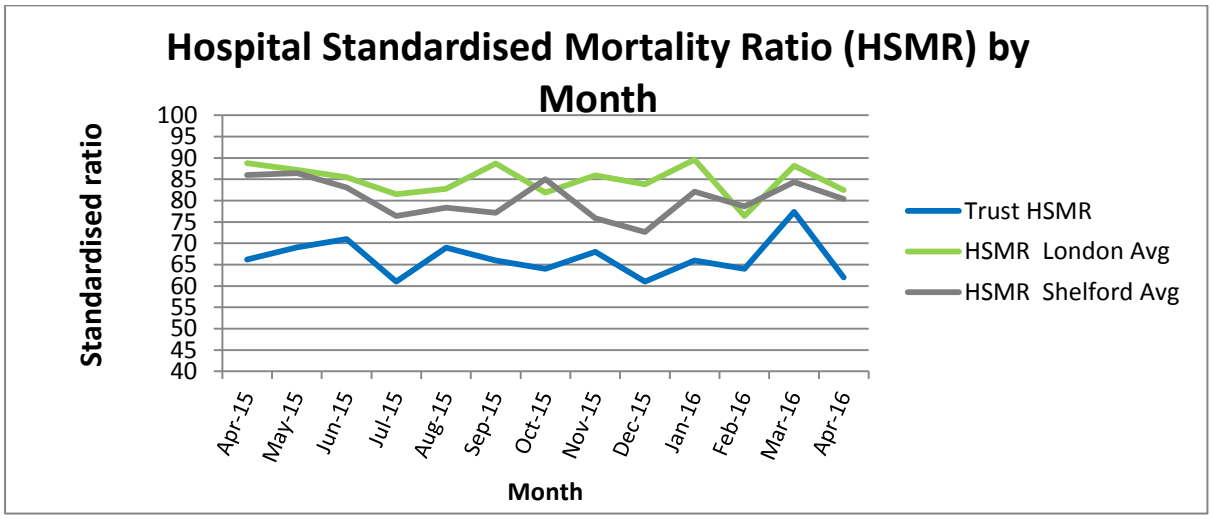


Figure 16 - Hospital Standardised Mortality Ratios for the period April 2015 – April 2016

1.2.3 Effective: Mortality reviews completed

Eighty eight per cent of deaths occurring in Q1 2016/17 have been reviewed by the divisions. Twelve deaths have been categorised as grade two (possible avoidable death) by the consultant conducting the initial review. Five of the 12 cases have been declared as an SI; the remaining seven are being reviewed by the Division of Surgery, Cancer and Cardiovascular Services.

1.2.4 Effective: Recruitment of patients into interventional studies

In quarter 4 2015/16, 92.2 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.

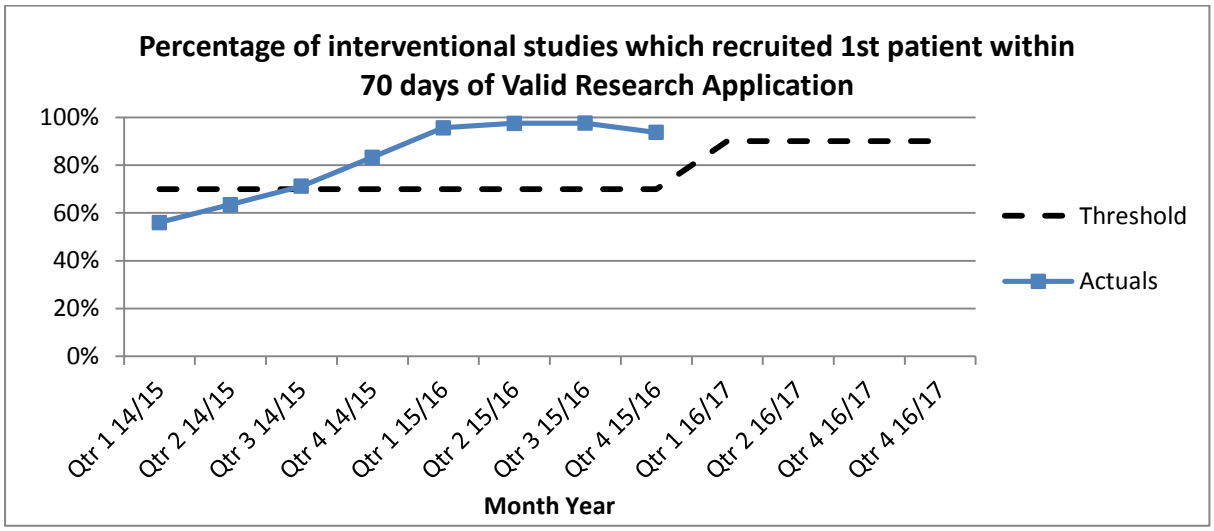


Figure 17 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q4 2015/16

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.

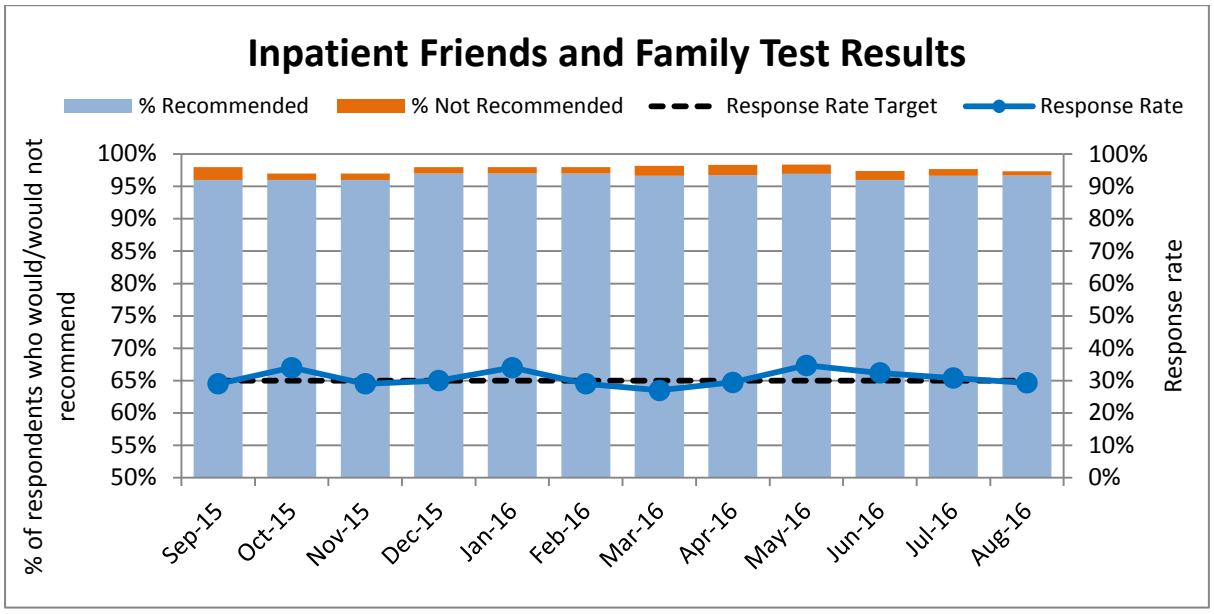


Figure 18 - Friends and Family (Inpatients) for the period September 2015 – August 2016

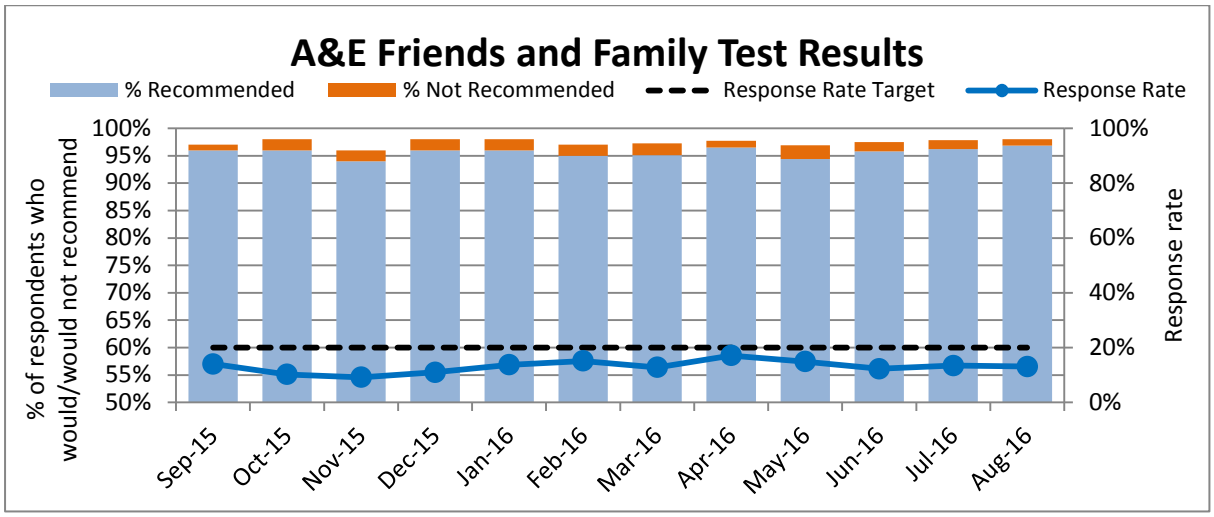


Figure 19 - Friends and Family (Accident and Emergency) for the period September 2015 – August 2016

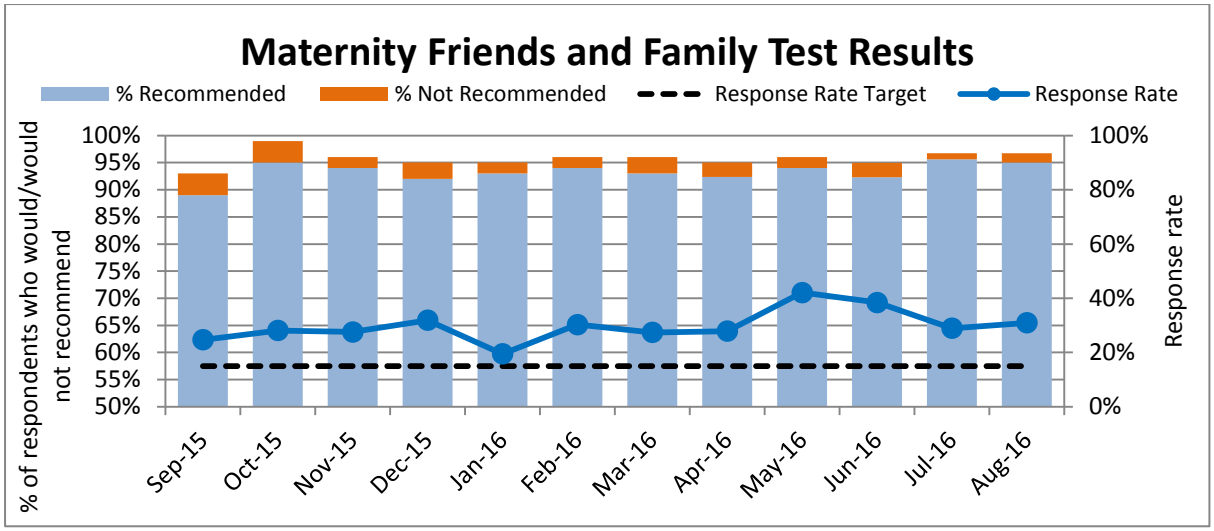


Figure 20 - Friends and Family (Maternity) for the period September 2015 – August 2016

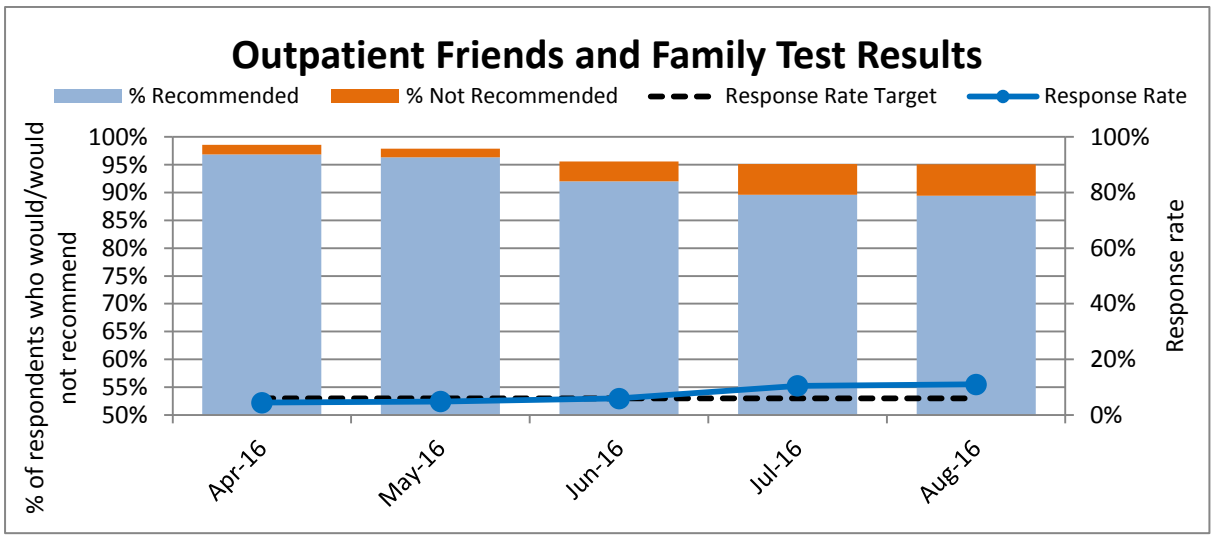


Figure 21 - Friends and Family (Outpatients) for the period April 2016 – August 2016

1.4 Well-Led

1.4.1 Well-Led: Vacancy rate

All Roles

At the end of August 2016, the Trust directly employed 9,627 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions and Research & Development areas.

The contractual vacancy rate for all roles was 11.63 per cent against the target of 10 per cent; an increase in month from the 11.16 per cent reported in July. The overall vacancy rate has been impacted by the delays in Occupational Health which resulted in very few candidates being OH cleared for a 7 week period between the end of June and middle of August. An interim solution has been put in place to manage this. Both the 'time to hire' and increase in the overall vacancy rate reflect this delay. The

Trust's voluntary turnover rate (rolling 12 month position) remains stable and shows a small reduction from 10.54 percent in July to the current 10.47 per cent; against the year-end target of 10 per cent or less.

Actions being taken to support reduction in vacancies include:

- Bespoke campaigns are underway for Radiographers, Imaging and Therapies
- A task and finish group for medical recruitment focusing on a new approach to recruiting hard to areas will run for the next 9 months.
- We are in the process of creating a new proactive approach to Administrative and Clerical recruitment which will start in October.
- A Trust Open Day will run at CXH on 27th September the response to this has been very positive.

There were 451 WTE candidates waiting to join the Trust across all occupational groups.

Bands 2 - 6 Nursing & Midwifery on Wards

At end of August 2016, the contractual vacancy rate for band 2-6 Nursing & Midwifery ward roles was 16.64 per cent with 405 WTE vacancies; reflecting a small increase from the July position (8 WTE additional vacancies) as a result of staff moving to non-ward areas through service changes and delays in health clearances for new staff. Further pressure comes from an 18 per cent turnover rate for this staffing group. However, the Trust continues to track lower that the London-wide situation of 17 per cent vacancy rate for all Nursing and Midwifery roles.

Actions being taken to support reduction in vacancies include:

- The new Band 5 rolling advert approach is now in place across all Divisions
- An attraction plan is being developed for theatres including: over-recruiting, changing the mix of Band 5 and 6s; and focused agency recruitment
- Attending the RCN fairs in Glasgow later in the Autumn and events at South Bank University and Bucks University in November
- The pilot for the more proactive rolling recruitment approach for Midwifery is yielding good results . It will also explore this for other hard to recruit areas
- Plans are underway to refresh the approach to the Student Nurse Recruitment for 2016/2017. A cohort of Student Nurses join the Trust in Sept/Oct
- The new internal Band 5 transfer process has commenced. Anecdotally this is being well received. The task and finish group will continue to enhance our N&M recruitment

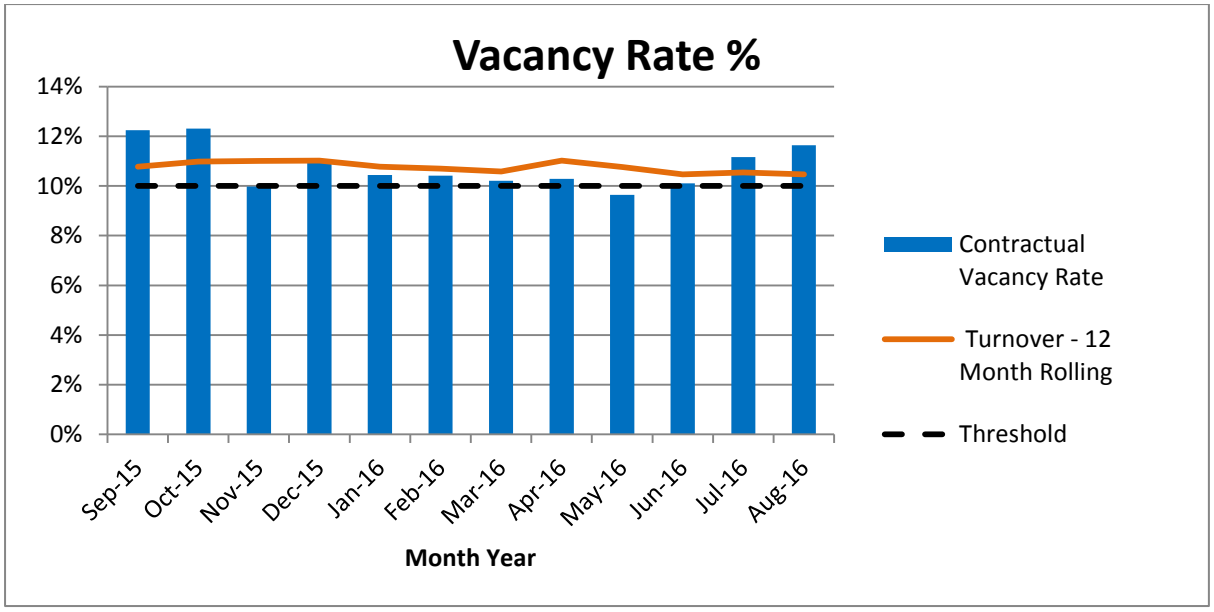


Figure 22 - Vacancy rates for the period September 2015 – August 2016

1.4.2 Well-Led: Sickness absence rate

In August 2016, recorded sickness absence was 2.66 per cent, against the target of 3.10 per cent.

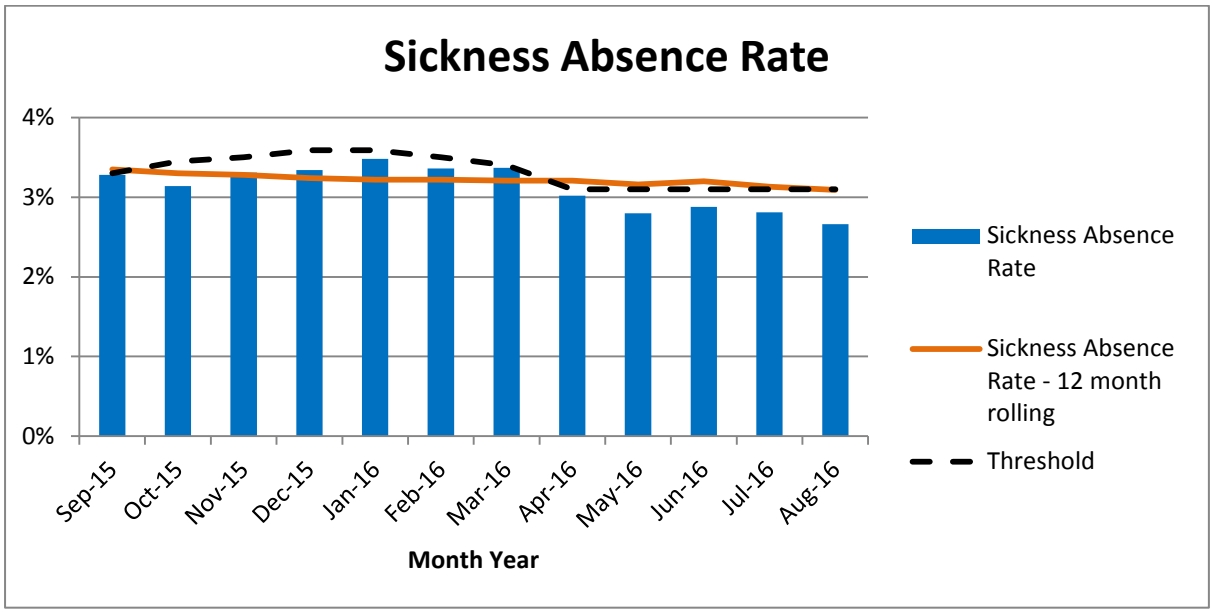


Figure 23 - Sickness absence rates for the period September 2015 – August 2016

1.4.3 Well-Led: Performance development reviews

The 2016/17 personal development review (PDR) cycle began on 1 April 2016 with all non-medical staff at bands 7 to 9, currently working, expected to have a completed PDR with their line manager by the end of June; the completion rate at end of August was 91.72 per cent with remaining PDRs scheduled as soon as possible. The remainder of staff on bands 2 – 6 are expected to have a completed PDR by the end of September.

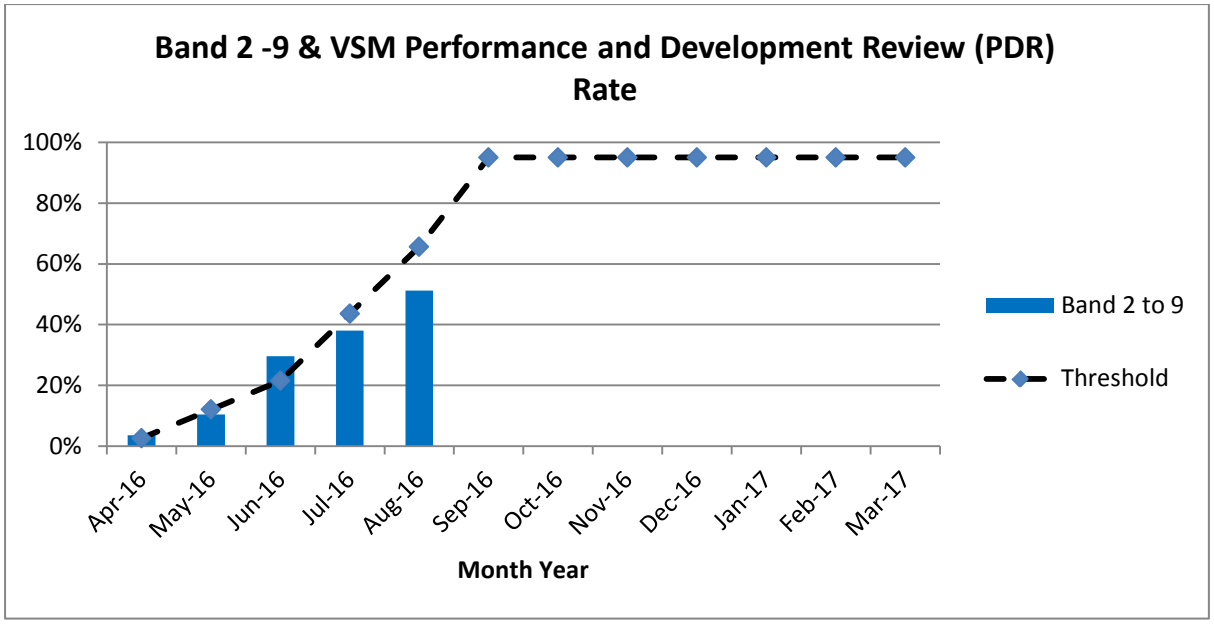


Figure 24 - Band 2 - 9 performance development review rates for the period April 2016 to March 2017

1.4.4 Well-Led: Doctor Appraisal Rate

Overall doctors' appraisal rates have increased slightly this month to 80.5 per cent.

As per Trust policy, review meetings are being arranged with doctors whose appraisals are overdue by 3 months to improve compliance.

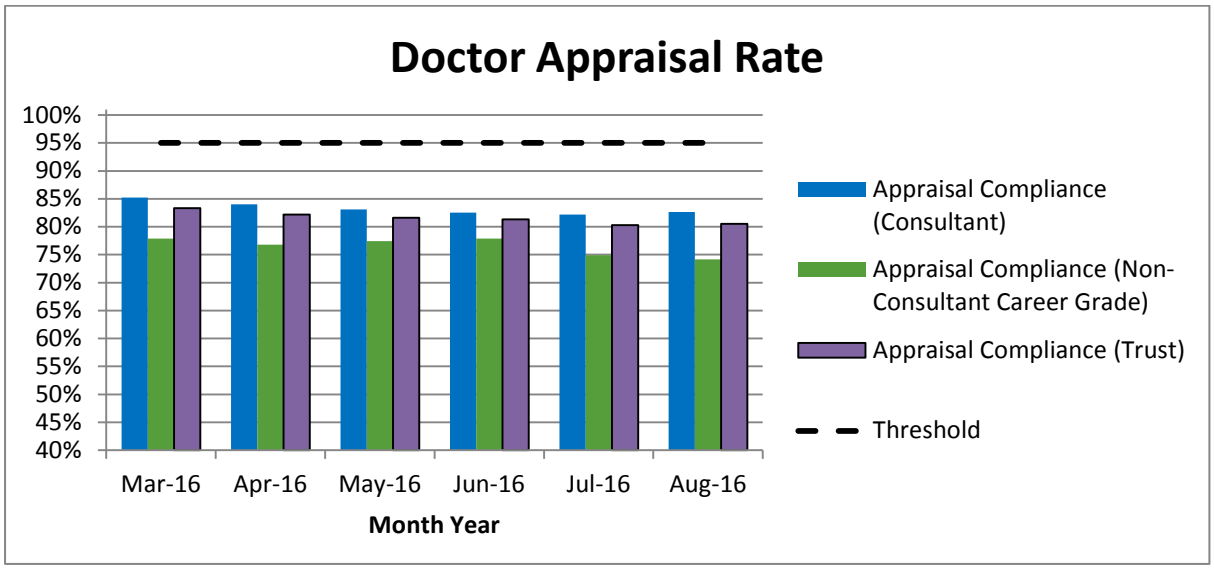


Figure 25 - Doctor Appraisal Rates for the period March 2016 to August 2016

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

2014/15 General Medical Council National Training Survey

All outstanding actions from the 2014/15 General Medical Council National Training Survey (GMC NTS) were confirmed as closed in June 2016.

Health Education North West London quality visit

There remain 59 actions open from the Health Education North West London quality visit action plan and a response to 38 was submitted in July 2016 with the next action plan submission due October 2016.

2015/16 General Medical Council National Training Survey

The results of the GMC NTS survey 2015/16 were published on 14th 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.

Action plans for all red flags are currently being developed by the relevant programmes/specialties. The Trust action plan is due to be submitted to Health Education England on 30th September 2016. The numbers of open and closed actions will then be monitored through this report from October 2016.

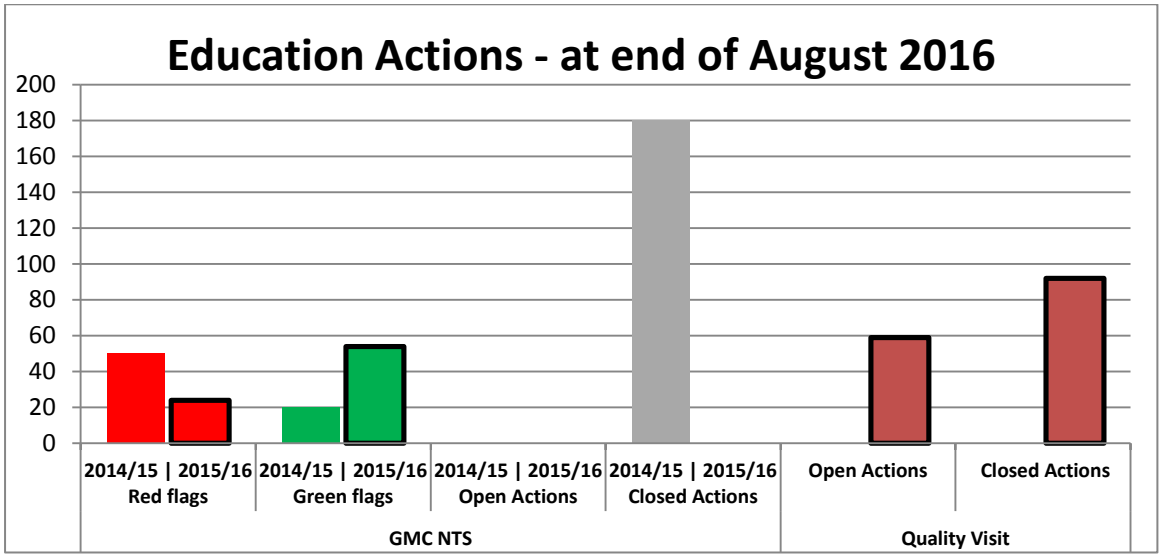


Figure 26 – General Medical Council - National Training Survey action tracker, updated at the end of August 2016

1.5 Responsive

1.5.1 Responsive: Consultant-led Referral to Treatment waiting times

The performance for August 2016 was 83.27 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.

At the end of August 2016, 10,028 patients were waiting over 18 weeks to reflecting a rapid growth in the 18 week backlog since February 2016 which was 4,890 patients on an incomplete pathway waiting over 18 weeks to receive treatment.

In February 2016 the Trust identified patients awaiting treatment that were not correctly recorded on the RTT patient tracking list and invited the NHS Improvement's Intensive Support Team to review our data quality. This led to a greater understanding of the issues and the action that we needed to take to resolve them. The Trust established a Waiting List Turnaround Improvement Programme in July, with external support, to address recommendations made by the NHS Elective Intensive Care Team and oversee 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 harm. System-wide governance arrangements have been established with our commissioners to oversee the improvement work and the Trust is receiving ongoing support from the IST.

The Trust Board paper on the Trust's Waiting List Improvement Programme provides further detail.

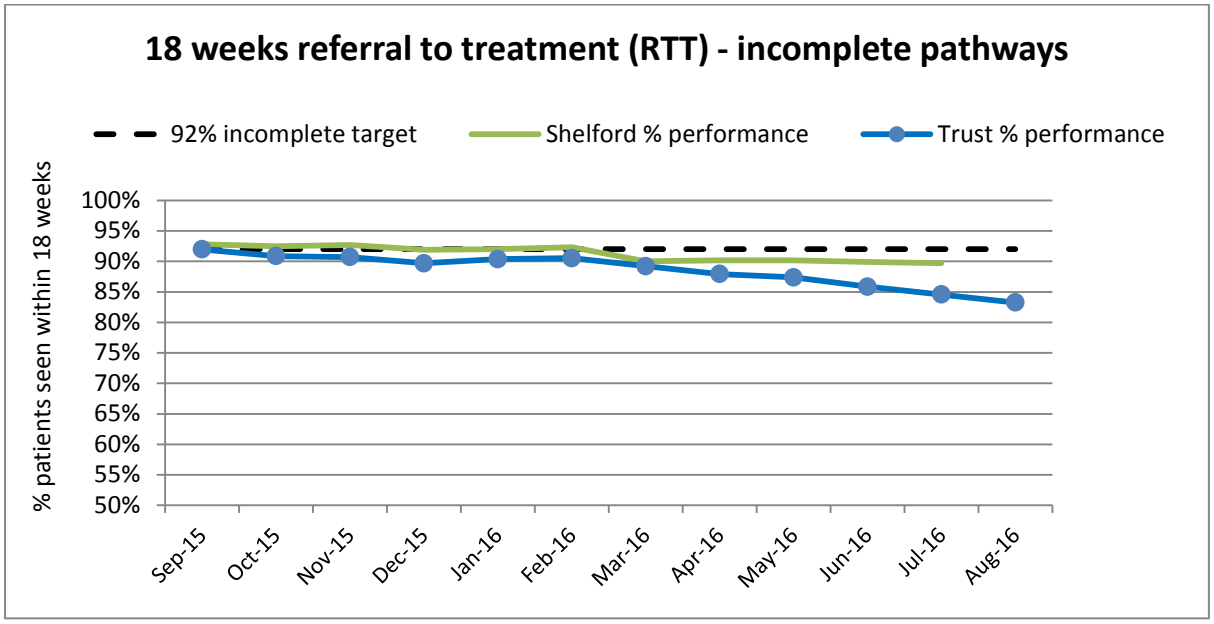


Figure 27 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period September 2015 – August 2016

52 weeks

At the end of August 2016, there were 83 patients who had waited over 52 weeks for their treatment since referral from their GP (not including patients on gender reassignment pathways).

Of the 83 patients reported as waiting over 52 weeks at end of July:

- 27 patients were previously reported as waiting over 52 weeks at end of June for whom clinical 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.
- 36 patients are patients whom we had not been tracking consistently because RTT rules were applied incorrectly at an earlier stage of the patient's treatment pathway. These patients were confirmed too late on the waiting list for treatment to be put in place.
- 20 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.
- Clinical reviews and treatments plans are being completed on all new patients waiting over 52 weeks at end August and have already commenced for September.
- An improvement trajectory for reducing known 52 week waiters (including gender reassignment patients) to zero by April 2017 has been agreed with NHS England. A new performance management and escalation process has been put into place to ensure that this trajectory can be delivered.

Gender reassignment surgery pathways

- 19 patients on gender reassignment surgery pathways had waited over 52 weeks at end August 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.

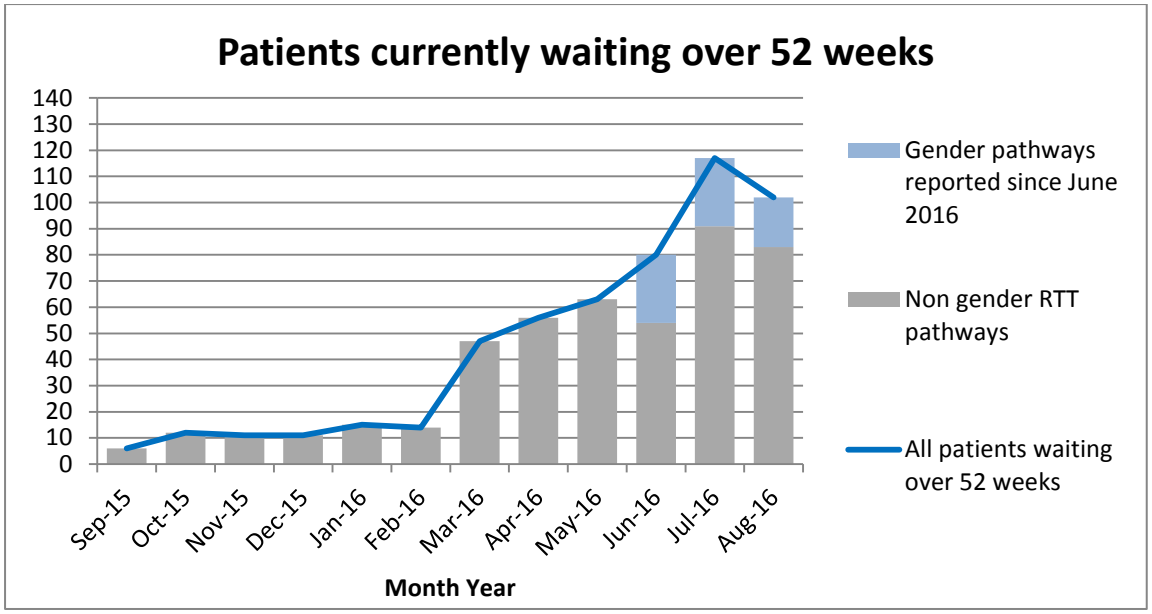


Figure 27 - Number of patients waiting over 52 weeks split by gender pathways and non-gender pathways, for the period September 2015 – August 2016

1.5.2 Responsive: Cancer

In August 2016, performance is reported for Cancer Waiting Times standards for July 2016. In July, the Trust achieved six of the eight national standards. The Trust underperformed against the 62-day GP referral to first treatment standard and underperformed against the 62-day screening standard.

Underperformance against the 62-day GP referral to first treatment standard in July was agreed with Commissioners as part of the Cancer Waiting Times recovery plan. The Trust over-performed against the GGC-agreed trajectory for the month and is on track to deliver continued improvement in August. The Trust has addressed significant pathway delays in urology and GI diagnostic pathways with an agreement to begin delivering the standard again from August 2016. Monthly meetings continue to take place with the Trust, CCG, NHSE and NHSI while this trajectory is delivered.

The Trust failed to deliver the 62-day screening standard due to unavoidable patient choice and complex pathway delays. There was no Trust-initiated contribution to the delays in any of the reported breaches.

The Trust recovered performance against the 2WW GP referral to first outpatient appointment in July, which was not delivered in June.

Indicator	Standard	July-16
Two week from GP referral to 1st outpatient – all urgent referrals (%)	93.0%	93.2%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.5%
31 day wait from diagnosis to first treatment (%)	96.0%	97.3%
31 day second or subsequent treatment (drug treatments) (%)	98.0%	100.0%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	100.0%
31 day second or subsequent treatment (surgery) (%)	94.0%	100.0%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	80.9%
62 day urgent GP referral to treatment from screening (%)	90.0%	86.0%

Table 1 - Performance against national cancer standards for July 2016

1.5.3 Responsive: Elective operations cancelled for non-clinical reasons

A total of 83 elective operations were cancelled on the day for non-clinical reasons in August. This equates to a cancellation rate of 0.95 per cent.

Eight patients whose operations were cancelled failed to be treated within the 28-day rebooking standard in August. Work to improve communication arrangements to minimise cancellations continues. Escalation processes for 28 day rebooking are being revised as part of a review of the Trust's elective access policy.

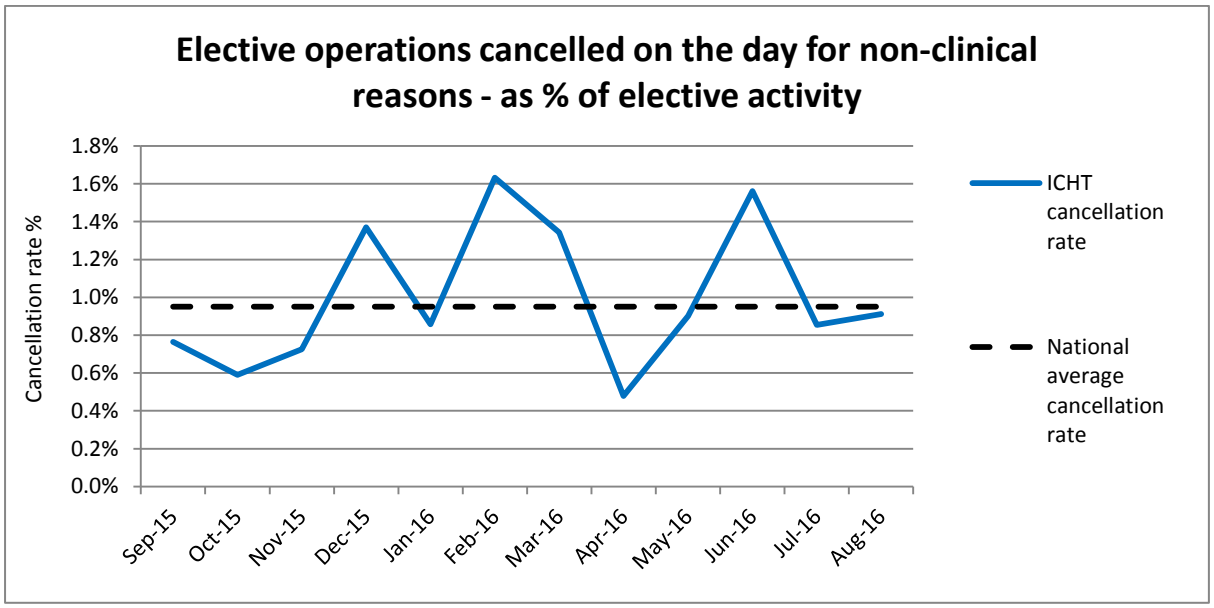


Figure 28 - Elective operations cancelled at the last minute for non-clinical reasons as a % of elective admissions for the period September 2015 – August 2016

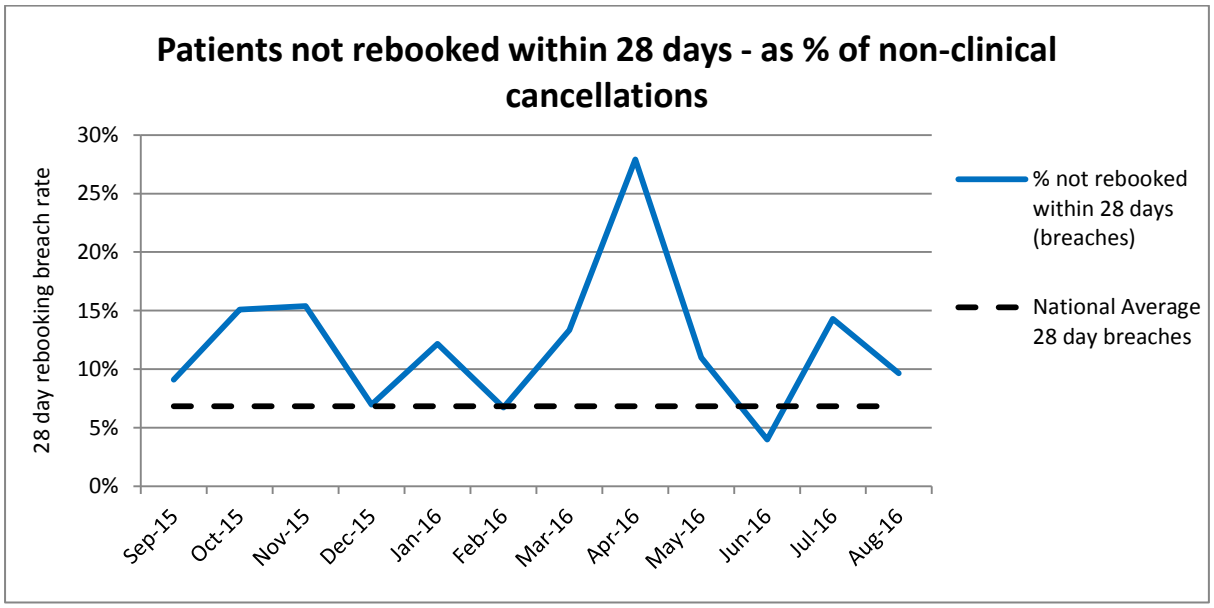


Figure 29 - Patients not treated within 28 days of their cancellation as a % of cancellations for the period September 2015 – August 2016

1.5.4 Responsive: Accident and Emergency

In August 2016, performance against the four hour access standard for patients attending Accident and Emergency was 90.75 per cent, meeting the performance trajectory target 90.06 per cent for the month.

The actions within the agreed recovery plan are on track.

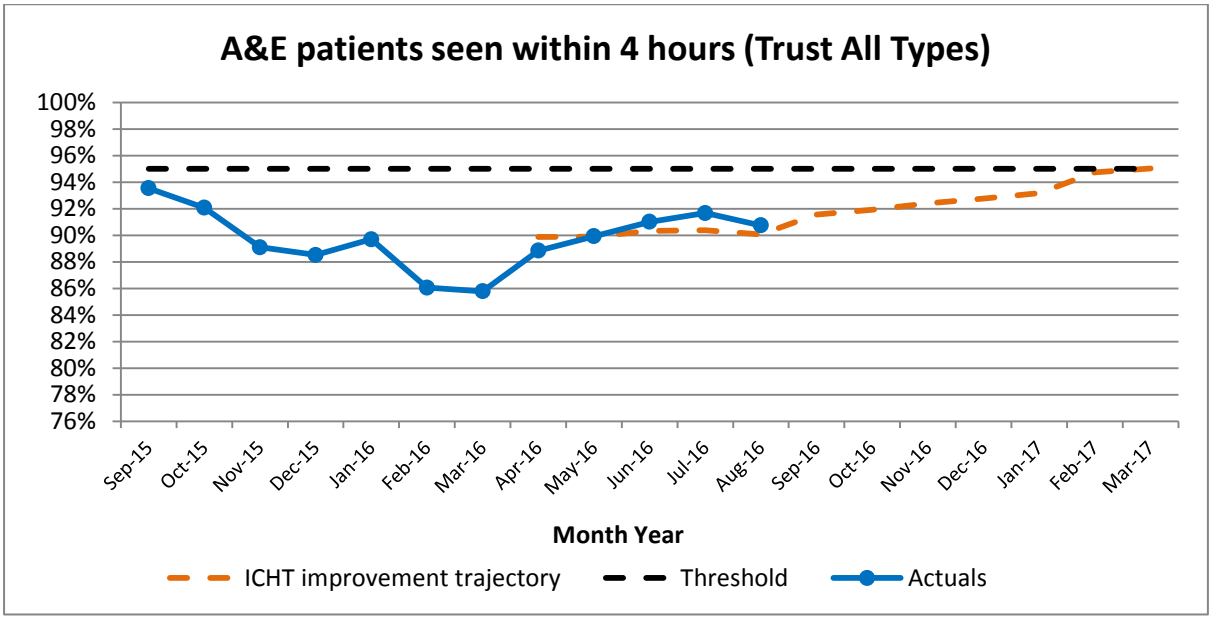


Figure 30 – A&E Maximum waiting times 4 hours (Trust All Types) for the period September 2015 – August 2016

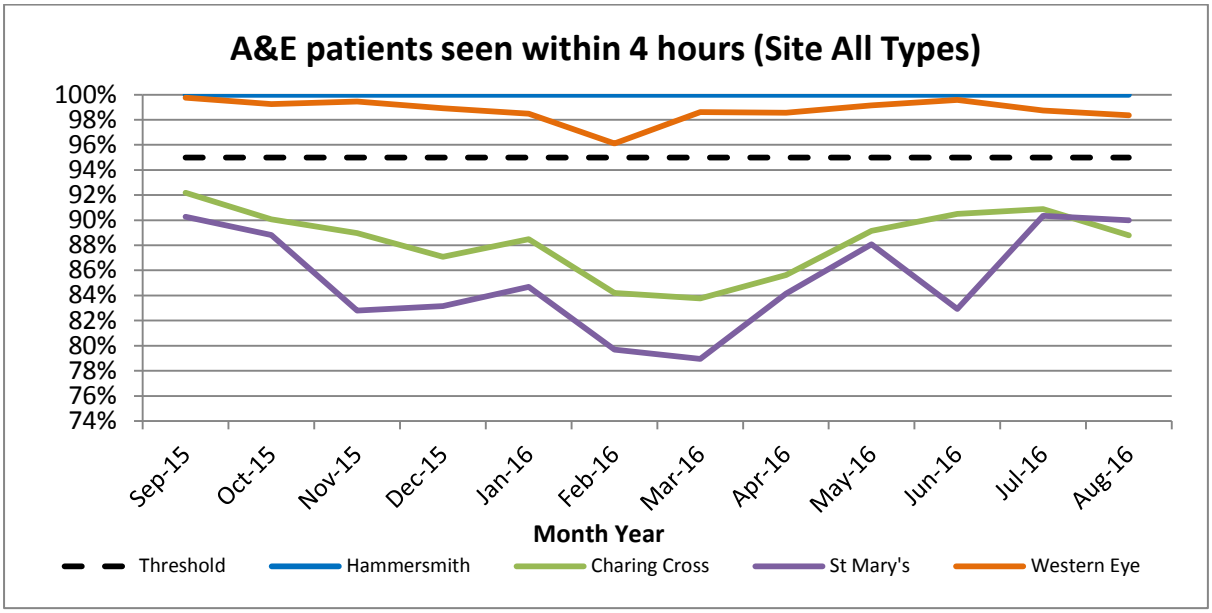


Figure 31 – A&E Maximum waiting times (Site All Types) 4 hours for the period September 2015 – August 2016

1.5.5 Responsive: Diagnostics

In August 2016, the Trust met the monthly 6 week diagnostic waiting time standard with 0.82 per cent of patients waiting over six weeks against a tolerance of 1 per

cent. Performance continues to meet the required standard each month. The Trust diagnostic review has been published internally with a set of key recommendations for action over the coming months.

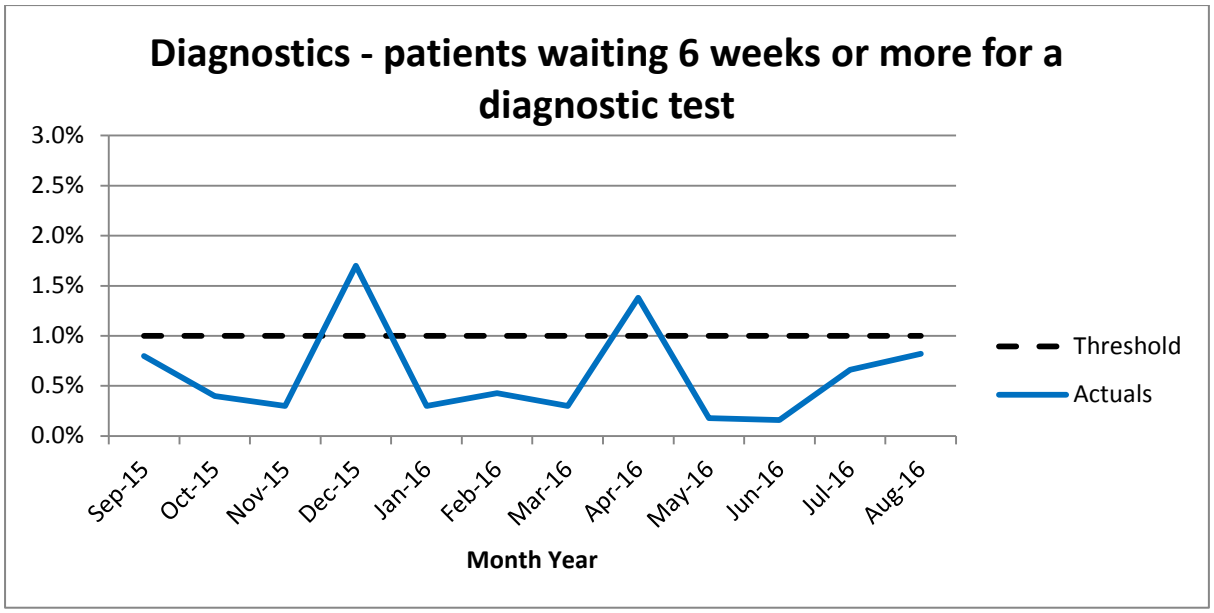


Figure 30 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period September 2015 – August 2016

1.5.6 Responsive: Patient attendance rates at outpatient appointments

The DNA rate (first and follow up) for August improved to 11.9 per cent compared to 12.2 per cent for July, equating to an average of 31 additional attendances a day.

Voice reminders went live for centrally managed services on 15 September and email reminders are scheduled to go live by the end of the month. These additional reminder mechanisms are expected to contribute to meeting our DNA rate.

Price Waterhouse Cooper is also providing support to implement processes and procedures to support the central booking, T&O and Gynaecology teams' adherence to appropriate elective access policy.

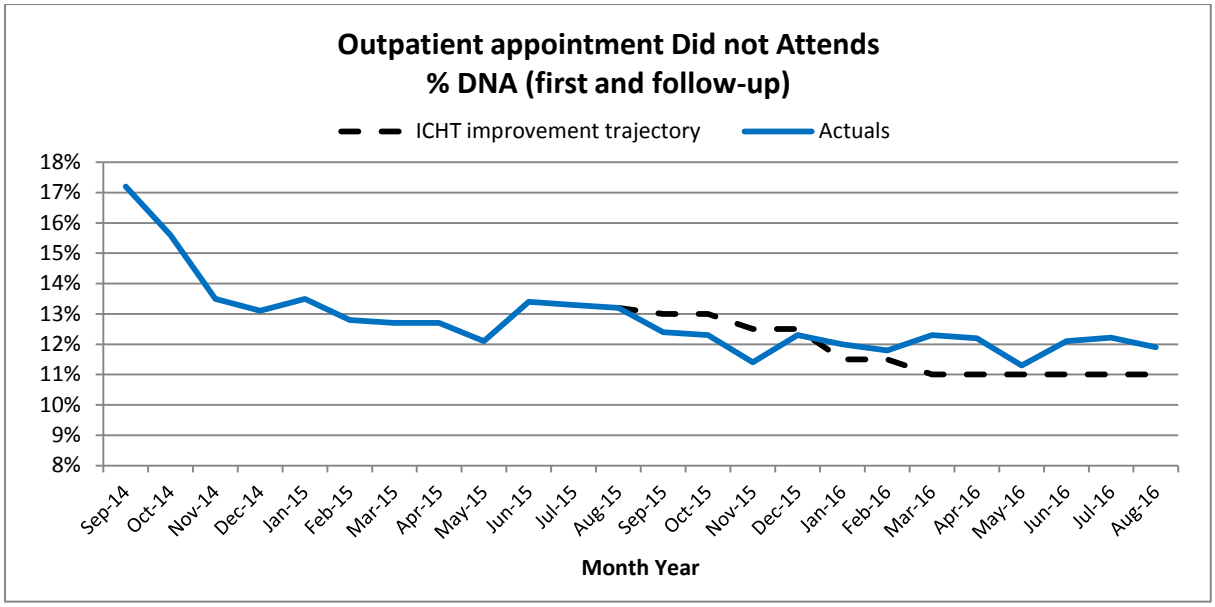


Figure 32 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period September 2014 – August 2016

1.5.3 Responsive: Outpatient appointments cancelled by the Trust

In August 2016, 16,464 outpatient appointments (14 per cent) were cancelled by the Trust with 9,681 (8.2 per cent) of these cancelled at less than 6 weeks' notice. This equates to 440 short notice cancellations per working day in comparison to 450 last month.

The Divisional Directors have agreed new authorisation procedures for short notice clinic cancellations. The updated policy will ratified through the Outpatient Improvement Programme steering group later this week and rolled out across the organisation.

Price Waterhouse Cooper is conducting a deep dive into the reasons behind short notice cancellations with a view to revising the reason codes on Cerner to improve the quality of the data captured.

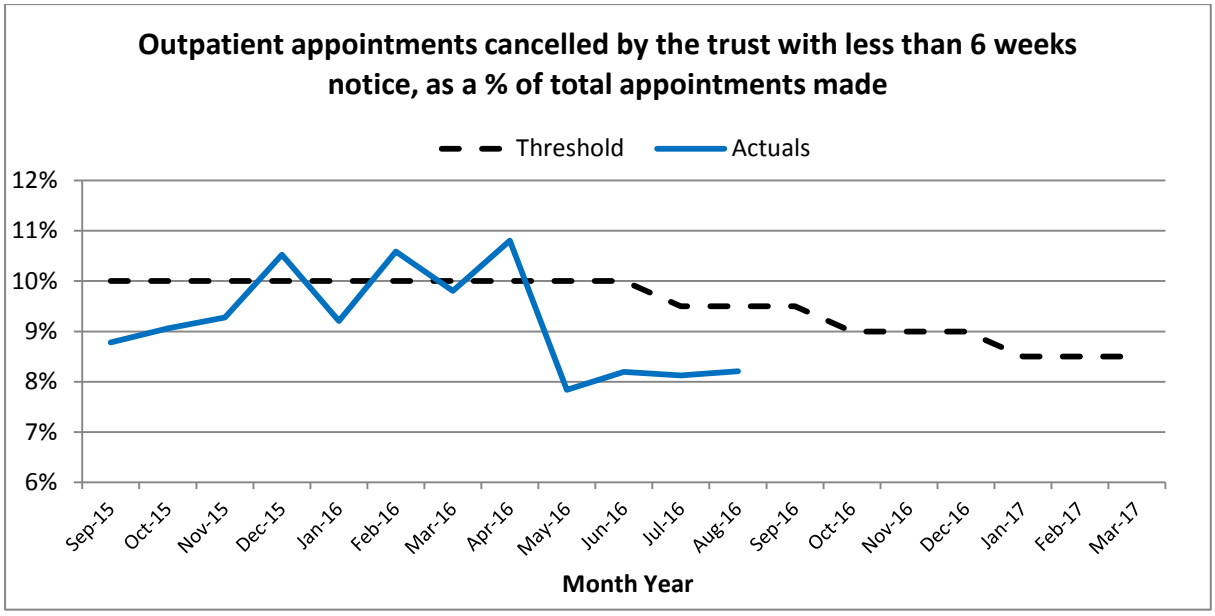


Figure 33 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period September 2015 – August 2016

1.5.4 Responsive: Access to antenatal care – booking appointment

In August 2016, 97 per cent of pregnant women accessing antenatal care services completed their booking appointment by 12 weeks and 6 days (excluding late referrals), against the target of 95 per cent or more. The Trust is expected to continue to achieve this access standard during 2016/17.

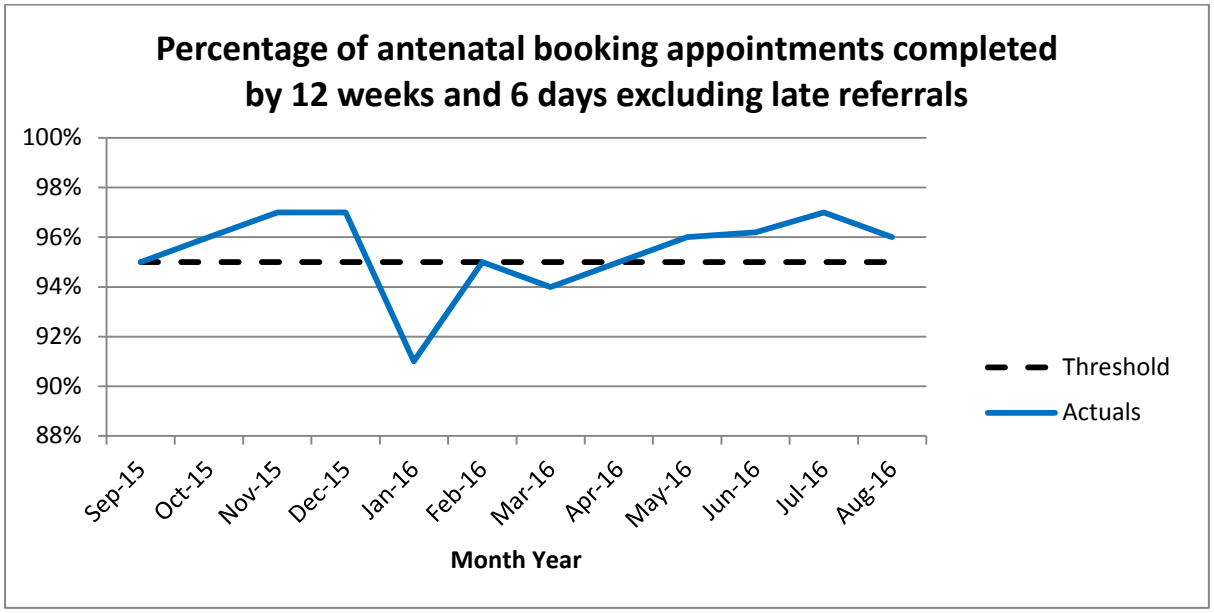


Figure 34 – Percentage of antenatal booking appointments completed by 12 weeks and 6 days excluding late referrals for the period September 2015 – August 2016

1.5.5 Responsive: Complaints

The number of formal complaints increased in August and there appears to have been an increase in the volume of appointments related complaints which is being followed up. Performance against acknowledgement and response time targets remains good.

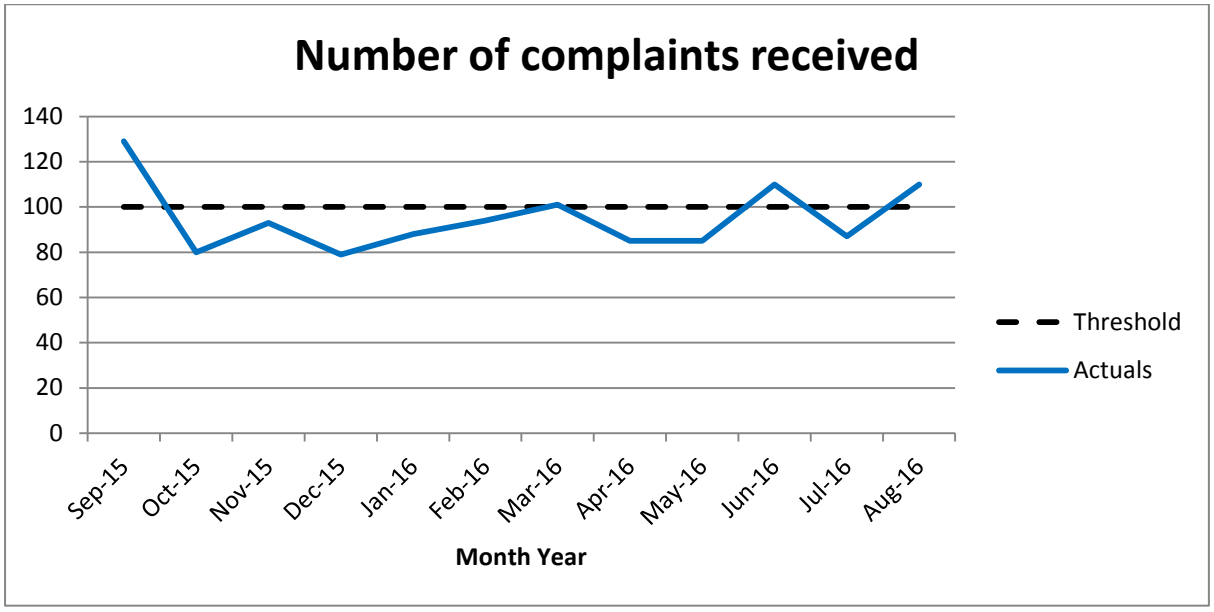


Figure 35 – Number of complaints received for the period September 2015 – August 2016

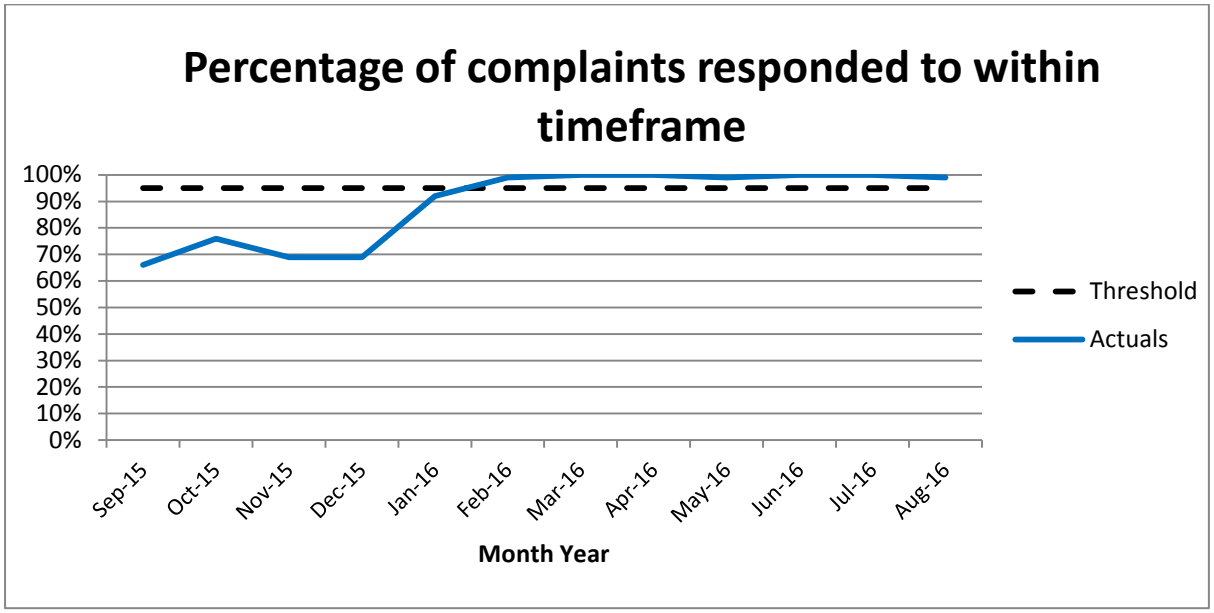


Figure 35 – Response times to complaints for the period September 2015 – August 2016

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	28 September 2016

Month 5 Finance report

Executive summary:

This paper presents the financial report for the Trust for the 5 months to August 2016. The Trust is meeting its financial plan year to date.

The committee is requested to note the finance report.

Quality impact:

Financial impact:

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

Risk impact:

Recommendation(s) to the Trust board

The Trust board is requested to note the finance report

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
Janice Stephens Deputy CFO	Richard Alexander CFO	22 September 2016

IMPERIAL COLLEGE HEALTHCARE NHS TRUST

FINANCE REPORT – 5 MONTHS ENDED 31st August 2016

1. Introduction

This report provides a brief summary of the Trust's financial results for the 5 months ended 31st August 2016. The Trust Board is asked to note this paper.

2. Summary

The Trust is reporting a deficit of £24.22m; a favourable variance to plan of £0.49m. 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	82.88	87.51	4.63	427.99	435.38	7.40
Pay	(50.28)	(49.26)	1.02	(250.33)	(245.06)	5.27
Non Pay	(34.52)	(40.27)	(5.76)	(176.28)	(188.81)	(12.53)
Reserves	(1.00)	(1.00)	(0.00)	(6.22)	(6.22)	(0.00)
EBITDA	(2.92)	(3.03)	(0.11)	(4.84)	(4.70)	0.14
Financing Costs	(1.91)	(3.23)	(1.32)	(15.37)	(18.42)	(3.05)
SURPLUS / (DEFICIT) including donated asset treatment	(4.83)	(6.26)	(1.43)	(20.21)	(23.12)	(2.91)
Donated Asset treatment	(2.11)	(0.67)	1.44	(4.50)	(1.10)	3.40
Impairment of Assets	-	-	-	-	-	
SURPLUS / (DEFICIT)	(6.95)	(6.94)	0.01	(24.71)	(24.22)	0.49

Income is above plan by £7.4m year to date. Income performance in month is high, the plan was low in August, based on expected activity trends over summer, however this reduction has not happened to the same level as in previous years. Pay is favourable to plan, in large part due to delays in recruiting staff for income generating CIP schemes. Within pay, agency costs continue to be below last year's spend and below the agency cap. Non Pay is adverse to plan, £3.3m of which relates to pass through costs which have offsetting favourable variances in income. Changes in classification of spend has resulted in a £1.2m underspend in pay and a

£1.2m overspend in non pay year to date. £2.8m of the non pay variance is due to unachieved CIP and QIPP (commissioner demand reduction) schemes.

3. Revenue

The Appendix provides a summary of the position after 5 months.

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
Division of Medicine and Integrated care	320,746	327,904	7,158	101.16	101.29	0.13
Division of Surgery, Cancer and Cardiovascular	247,888	237,872	(10,016)	114.64	113.39	(1.25)
Division of Women, Children and Clinical Support	987,037	1,008,999	21,962	60.81	61.85	1.04
Central Income	(1,006)	3	1,009	51.49	57.98	6.49
Clinical Commissioning Income	1,554,665	1,574,778	20,113	328.10	334.51	6.41

Central Income includes 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. Notably income from accident and emergency is above plan driven by lower than expected levels of activity being delivered in the Urgent Care Centre. Adult critical care is less than plan due to corrections to coding.

3.2 Private Care income

Private care income has improved against plan since April however in month income was £0.03m behind plan and £0.34m behind plan year to date. The income plan for this 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	21.94	22.18	0.24	108.13	108.31	0.18
Expenditure	(17.03)	(16.92)	0.11	(87.09)	(87.31)	(0.22)
Medicine and Integrated Care	4.91	5.27	0.36	21.04	21.01	(0.03)
Income	23.83	23.63	(0.20)	116.40	115.38	(1.02)
Expenditure	(20.50)	(20.59)	(0.09)	(102.32)	(101.63)	0.69
Surgery, Cancer and Cardiovascular	3.34	3.04	(0.30)	14.08	13.75	(0.33)
Income	15.43	14.76	(0.67)	76.08	76.89	0.81
Expenditure	(17.03)	(17.41)	(0.38)	(85.89)	(85.15)	0.74
Women, Children & Clinical Support	(1.60)	(2.66)	(1.06)	(9.81)	(8.26)	1.55
Imperial Private Healthcare	0.70	0.95	0.25	4.80	5.13	0.33
Total Clinical Division	7.35	6.60	(0.75)	30.11	31.63	1.52

Medicine is broadly on plan. The Division of Surgery is £0.33m behind plan driven in the main by slippage on CIP schemes and loss of activity in April due to junior doctor strikes and theatre closures. The Division of Women and Children and Clinical Support is favourable to plan by £1.6m, this is driven by above plan income performance and underspends particularly on pay. Private Health is favourable to plan year to date by £0.33m: whilst income is behind plan, costs are being contained to offset that.

4. Efficiency programme

CIP delivery in the first 5 months of the year was adverse to plan by £3.3m. The main driver for the Surgery, Cancer and Cardiovascular Division are income generation 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. The Trust is working with PWC through its Financial Improvement Plan to ensure that new CIP plans crystalize and CIPs are delivered in full.

5. Cash

The cash balance at the end of the month was £25.2m.

6. Conclusion

The Trust is on plan year to date. There are a number of risks, notably delivery of the CIP programme which require the Executive to continue to work internally to reduce costs while safeguarding quality and with the commissioners and NHSI to ensure fair remuneration for activity carried out.

The Trust Board is requested to note this report.

Appendix

Statement of Comprehensive Income – 5 months to 31st August 2016

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	64.88	70.15	5.27	336.19	347.16	10.97
Private Patients	3.56	3.53	(0.03)	19.60	19.27	(0.34)
Research & Development & Education	9.03	9.13	0.11	45.14	44.07	(1.07)
Other	5.41	4.69	(0.72)	27.06	24.89	(2.17)
TOTAL INCOME	**82.88**	**87.51**	**4.63**	**427.99**	**435.38**	**7.40**
Expenditure						
Pay - In post	(48.33)	(43.38)	4.94	(242.13)	(216.44)	25.69
Pay - Bank	(0.64)	(3.34)	(2.70)	(3.28)	(15.83)	(12.55)
Pay - Agency	(1.31)	(2.54)	(1.22)	(4.92)	(12.80)	(7.87)
Drugs & Clinical Supplies	(23.15)	(24.23)	(1.08)	(115.58)	(118.83)	(3.25)
General Supplies	(2.82)	(3.19)	(0.37)	(14.05)	(15.13)	(1.08)
Other	(8.55)	(12.86)	(4.31)	(46.65)	(54.84)	(8.19)
TOTAL EXPENDITURE	**(84.80)**	**(89.54)**	**(4.74)**	**(426.61)**	**(433.86)**	**(7.26)**
Reserves	**(1.00)**	**(1.00)**	**0.00**	**(6.22)**	**(6.22)**	**0.00**
Earnings Before Interest, Tax, Depreciation & Amortisation	**(2.92)**	**(3.03)**	**(0.11)**	**(4.84)**	**(4.70)**	**0.14**
Financing Costs	(1.91)	(3.23)	(1.32)	(15.37)	(18.42)	(3.05)
SURPLUS / (DEFICIT) including donated asset treatment	**(4.83)**	**(6.26)**	**(1.43)**	**(20.21)**	**(23.12)**	**(2.91)**
Donated Asset treatment	(2.11)	(0.67)	1.44	(4.50)	(1.10)	3.40
Impairment of Assets	0.00	0.00	0.00	0.00	0.00	0.00
SURPLUS / (DEFICIT)	**(6.95)**	**(6.94)**	**0.01**	**(24.71)**	**(24.22)**	**0.49**

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust Board - public	**28 September 2016**

Waiting list improvement plan

Executive summary:

The Trust has not been meeting the national standard for referral to treatment (RTT) performance – for at least 92 per cent of patients to be treated within 18 weeks of referral. We reported performance for August 2016 of 83 per cent. We have also been reporting an increase in patients waiting over 52 weeks – we reported 102 patients for August against a national standard of zero.

This paper sets out the background to our waiting list issues as well as the waiting list improvement programme we have established with the support of NHS Improvement's Elective Care Intensive Support Team (IST), and in close liaison with our commissioners and regulators.

As previously reported to the public Trust board, we decided to bring in external expertise to support us in addressing a number of underlying issues with our waiting list management in February 2016. Our data validation team had picked up inconsistencies in how waiting list processes were being managed, there were some continuing data quality issues, and we were not planning in enough outpatient and elective treatment capacity to meet demand.

While the issues appeared to be focused primarily in a small number of specialties and we were able to respond immediately to individual patients picked up as long waiters, we wanted fully to understand the issues across all specialties and to develop a systematic approach to improvements.

With the support of our local commissioners, we invited IST to review our information systems and processes, data validation and rules application in relation to the 18 weeks RTT standard.

In response to the IST report, we have established a waiting list improvement programme to develop and implement an action plan to:

- support the office of the medical director in embedding processes to assure patient safety
- put in place and maintain best practice waiting list management processes
- complete work to ensure a fully comprehensive and accurate understanding of all of our waiting lists
- improve our systems and processes to ensure good data quality at point of entry

- achieve the national waiting list standard sustainably.

The programme is driven by a dedicated waiting list improvement team supported by an external waiting list expert and continues to also be supported by IST. The programme incorporates the following work streams:

- establishing comprehensive and accurate data quality
- focus on treating patients waiting over 52 weeks
- improving responsiveness, including through increased capacity both within the Trust and with the support of independent sector providers
- improving waiting list management processes and data quality practice
- governance and monitoring.

Quality impact:

The waiting list improvement programme is essential to ensure responsive and safe care for all our patients.

Financial impact:

The costs of the waiting list improvement programme are met by the Trust from this year's contingency budget. The costs of additional activity required to meet RTT targets are funded through our contracts with Commissioners.

Risk impact:

The actions described in this paper are intended to address the risks of not meeting NHS constitutional standards and not delivering care to our patients in a timely manner.

Recommendation(s) to the Trust board:

The Trust board is asked to note and comment on the report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Martin Lerner, DDO, SCC Division	Prof Jamil Mayet Divisional Director	22 September 2017

Waiting list improvement plan

Background

The Trust has not been meeting the national standard for referral to treatment (RTT) performance – for at least 92 per cent of patients to be treated within 18 weeks of referral. We reported performance for August 2016 of 83 per cent. We have also been reporting an increase in patients waiting over 52 weeks – we reported 102 patients for August against a national standard of zero.

This paper sets out the background to our waiting list issues as well as the waiting list improvement programme we have established with the support of NHS Improvement's Elective Care Intensive Support Team (IST), and in close liaison with our commissioners and regulators, in order to:

- be assured of patient safety as a priority
- to make immediate improvements in responsiveness
- return to meeting the national standard sustainably as soon as possible.

Identification of the issues

As previously reported to the public Trust board, we decided to bring in external expertise to support us in addressing a number of underlying issues with our waiting list management in February 2016. Our data validation team had picked up inconsistencies in how waiting list processes were being managed, there were some continuing data quality issues, and we were not planning in enough outpatient and elective treatment capacity to meet demand.

While the issues appeared to be focused primarily in a small number of specialties and we were able to respond immediately to individual patients picked up as long waiters, we wanted fully to understand the issues across all specialties and to develop a systematic approach to improvements.

With the support of our local commissioners, we invited IST to review our information systems and processes, data validation and rules application in relation to the 18 weeks RTT standard.

Following this comprehensive review, IST recommended in July 2016 that we undertake a number of detailed audits to build a more comprehensive understanding of all of our waiting lists and make a number of immediate improvements to our waiting list processes. They concluded that:

- The review identified a well-developed and effective process for validation of long waiting incomplete pathways but also identified gaps in the Trust's sampling methodology which may present the risk of unidentified long waiting patients.
- The Trust was able to describe its RTT data handling processes well and this is found to be broadly consistent with normal practice. A number of concerns have been highlighted, however, which relate to datasets that are excluded from RTT monitoring, some of which require urgent further investigation.

IST also found that we have a number of data quality issues, and made recommendations to ensure these issues are fully resolved. These data quality

issues arose after the implementation of our new patient administration system in April 2014.

Assuring patient safety

We recognise that extended delays will negatively affect patients' experience of care and cause associated anxiety and distress. While we are focusing on minimising delays and improving our waiting list processes to ensure patients are treated in a timely manner, we have implemented robust arrangements to ensure that patients are not coming to clinical harm as a result of waiting too long. This includes a retrospective analysis of patients who were treated after waiting more than 18 weeks from referral, and on-going review of patients who are still waiting too long for their treatment. These are described below in further detail.

Retrospective clinical review
A retrospective review of cases that waited over 18 weeks for treatment in 2014/15 was undertaken by our deputy medical director last year: of the 6,247 patients reviewed, one case was identified where a patient deteriorated while awaiting treatment on the waiting list. This case had already been picked up by the Trust's internal governance processes and investigated as a serious incident. We are currently repeating this review for patients who waited between April 2015 and June 2016.

On-going clinical review
Processes are in place for consultant review of the records of all patients waiting over 52 weeks for treatment, and for review of patients over 18 weeks in specific specialties where the risks of clinical harm are higher. A summary of these clinical reviews is reported on a monthly basis to the Trust's Executive Quality Committee and Trust board sub-committee, the Quality Committee through the quality report, which is also reviewed at the joint local commissioners/Trust Clinical Quality Group meeting. All patients waiting over 52 weeks since March 2016 have been reviewed through this process. So far, none have been found to have suffered clinical harm as a consequence of their wait. We are also working with local commissioners to find ways to improve the monitoring of any adverse impact on patients, for example by improving how we might link with feedback received by GPs.

Waiting list improvement programme

In response to the IST report, we have established a waiting list improvement programme to develop and implement an action plan to:

- support the office of the medical director in embedding processes to assure patient safety
- put in place and maintain best practice waiting list management processes
- complete work to ensure a fully comprehensive and accurate understanding of all of our waiting lists
- improve our systems and processes to ensure good data quality at point of entry
- achieve the national waiting list standard sustainably.

The programme is driven by a dedicated waiting list improvement team led by an

external waiting list expert and continues to be supported by IST. The programme incorporates the following work streams:

Establishing comprehensive and accurate data quality
After assuring patient safety, our key priority has been to complete work to have a fully comprehensive and accurate understanding of all of our waiting lists. Audits have given good assurance that the number of patients on our inpatient waiting list who should have been included in the RTT standard monitoring is very low in most specialties. There are, however, significant issues with six specialties – trauma and orthopaedics; ophthalmology; ear, nose and throat; plastic surgery; hepato-pancreato-biliary; and pain management. The RTT status for all patients in these six specialties is now being reviewed and action taken on a case-by-case basis. We are undertaking a similar process for patients on our outpatient, planned waiting and deleted waiting lists. This work will be fully completed by December with the support of additional data validators.

Focus on treating patients waiting over 52 weeks
As well as patients on our RTT reports who have been waiting over 52 weeks, there is a further subset of patients on our waiting lists who we have not been appropriately tracked through our RTT reports and have, as a consequence, been allowed to wait for treatment for over 52 weeks. As such, as we complete our comprehensive and accurate understanding of all our waiting lists, we are seeing a gradual rise in the number of long-wait RTT patients. We expect to identify a number of additional long-wait patients through the intensive data quality work underway that will be completed by December.

Of the patients waiting over 52 weeks at the end of August, 47 were on our RTT report and arrangements are in place for their treatment, 36 were not being appropriately tracked through our RTT reports and their treatment is being agreed and booked urgently as they are identified. The remaining 19 long-wait patients are waiting for gender reassignment surgery – following the recent agreement with NHS England to monitor this cohort of patients in line with standard RTT reporting, we have confirmed a capacity plan with our specialist commissioners to provide surgery for all long-wait patients by the end of March.

Improving responsiveness, including through increased capacity
General managers for each of our specialties are now responsible for specialty-specific action plans to address all aspects of underlying RTT performance issues. These plans include a combination of additional data validation, ensuring that all necessary booking actions take place to follow up patients who still need treatment, additional outpatient capacity, and additional inpatient theatre capacity as required.

A mobile operating theatre is in place at Charing Cross Hospital to provide additional capacity while the Riverside theatres at the hospital are being refurbished, and further significant increases in theatre capacity are planned from January when Riverside theatres will re-open.

However, our assessment is that these actions will not on their own be sufficient to deliver the capacity required to return to meeting the 18 week RTT standard sustainably by the end of this financial year. We are therefore putting in place

arrangements for some patients, if they choose, to be treated by independent sector providers. This will apply in five surgical specialties - orthopaedics, neurosurgery, general surgery, ENT, urology - and this choice will be offered to suitable patients for both outpatient consultations and inpatient or day case treatment.

Improving waiting list management processes and data quality practice
We are putting in place improved systems and processes to ensure all our waiting lists are managed as effectively as possible. This will include further education and training for all staff groups involved in managing waiting lists and RTT performance. Clinicians will be provided with additional training and support to ensure that good data quality at point of input to our Cerner patient administration system. We are also continuing to work closely with Cerner on on-going improvements to the system to make it as easy as possible for staff to input and use data to support waiting list management and RTT tracking.

Governance and monitoring
Our waiting list improvement programme is overseen by a steering group chaired by Prof Jamil Mayet, divisional director of surgery, cancer, and cardiovascular services who has the lead responsibility for RTT targets within the Trust. Our local commissioners, NHS Improvement, IST and NHSE are part of this steering group. The steering group oversees the actions and monitors detailed progress reports on each of the actions and associated metrics. This joint governance arrangement is supported by internal arrangements which include all clinical divisions and general managers, who take responsibility for the actions in relation to their individual specialties, as part of the overall improvement plan. There is a weekly progress meeting chaired by our chief executive Dr Tracey Batten.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28th September 2016

North West London Sustainability and Transformation Plan

Executive summary:

1. Introduction

1.1National 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) Five Year Forward View (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, from next year, 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 ratings of 'Good' or 'Outstanding', includes progress against STP milestones in its assessment criteria.

1.2 Assessment Process

A 'checkpoint' submission of the first full draft version of the STP was submitted to NHSE and NHSI on the 30th June 2016. **Appendix 1** presents the June checkpoint North West London (NWL) STP document in full.

The June STP checkpoint submission set out a shared ambition across partner organisations to create an integrated health and care system that plans and delivers services based on population need and aims to do this by addressing the wider social determinants of health to enable people to live well and be well.

As part of a national assessment process to determine the readiness to implement the plans, members of the NWL STP senior leadership group presented the STP to NHSE and NHSI on the 14th July.

Feedback on the June submission from NHSE and NHSI, as well as feedback arising from NWL stakeholder engagement events and comments from health and social care partners is being responded to within the next iteration of the plan which will be submitted on the 21th October 2016.

1.3 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 £4m.

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.

If we continue to provide care in the way that we do now, the gap between how much money will be required and what is likely to be available will become ever more unsustainable, with an estimated the shortfall of £1.3b in NWL by 2021.

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

2.1 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.

2.2 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.

2.3 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 £1.3bn financial gap by 2021 in our health and social care system

- Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

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

3.1 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 increasingly working jointly with social care and the wider community. Key changes include an expected expansion of local pooled budgets and implementing Accountable Care Partnerships across NWL with capitated budgets, population based outcomes and joint commissioning.

3.2 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

3.3 Five Delivery Areas and 22 Plans

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 and which will be aligned with the work of the Imperial Health Partners, the Academic Health Science Network (AHSN).

Each DA will have a jointly led work programme with a senior responsible officer, senior clinical responsible officer, commissioning representatives and programme support. DAs and their individual plans are as follows:

Delivery area (DA)	Plans
DA1. Radically upgrade prevention and wellbeing	a. Enabling and supporting healthier living b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
DA2. Eliminating unwarranted variation and improving long term condition management	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. 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. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. 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. Addressing wider determinants of health 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 acute services	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

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.

3.3 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.

4.Governance of the NWL STP

The work underpinning our STP is co-ordinated through a Strategic Planning Group (SPG) chaired by Dr Mohini Parmar, Chair Ealing CCG. Our Trust Chief Executive Dr Tracey Batten is the provider sector lead for the group. The SPG reports to the existing statutory bodies in NWL and has no decision-making powers.

To support the delivery of the aspirations within our STP a comprehensive, multi-agency implementation programme and governance framework is being developed. A Joint NWL Health and Care Transformation Group will oversee the delivery of our STP. Our Trust Chief Executive is also a member of this group and is a programme sponsor for DA5.

It is important to note that, to date, whilst all of the health providers in NWL gave their support to the checklist submission of the 30th June 2016, only six out of the eight local boroughs have indicated their support given the 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.

5. Action

The Board is asked to approve in principal the NWL STP as currently drafted and to give delegated authority to the Chief Executive to approve the final version for submission subject to the nature of proposed amendments.

Quality impact:

Successful implementation of the NWL STP aims to reduce unwarranted variations in quality of care and 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 successful implementation of the STP work programme, financial risks in the short–term for acute providers as resource allocation and commissioning intentions are reshaped, eligibility and timing to access STF

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	21st September 2016

NW London Sustainability and Transformation Plan

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

V1.0

30 June 2016

DRAFT

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 £1.3bn 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.

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

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 have a life expectancy 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 £1.3bn 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

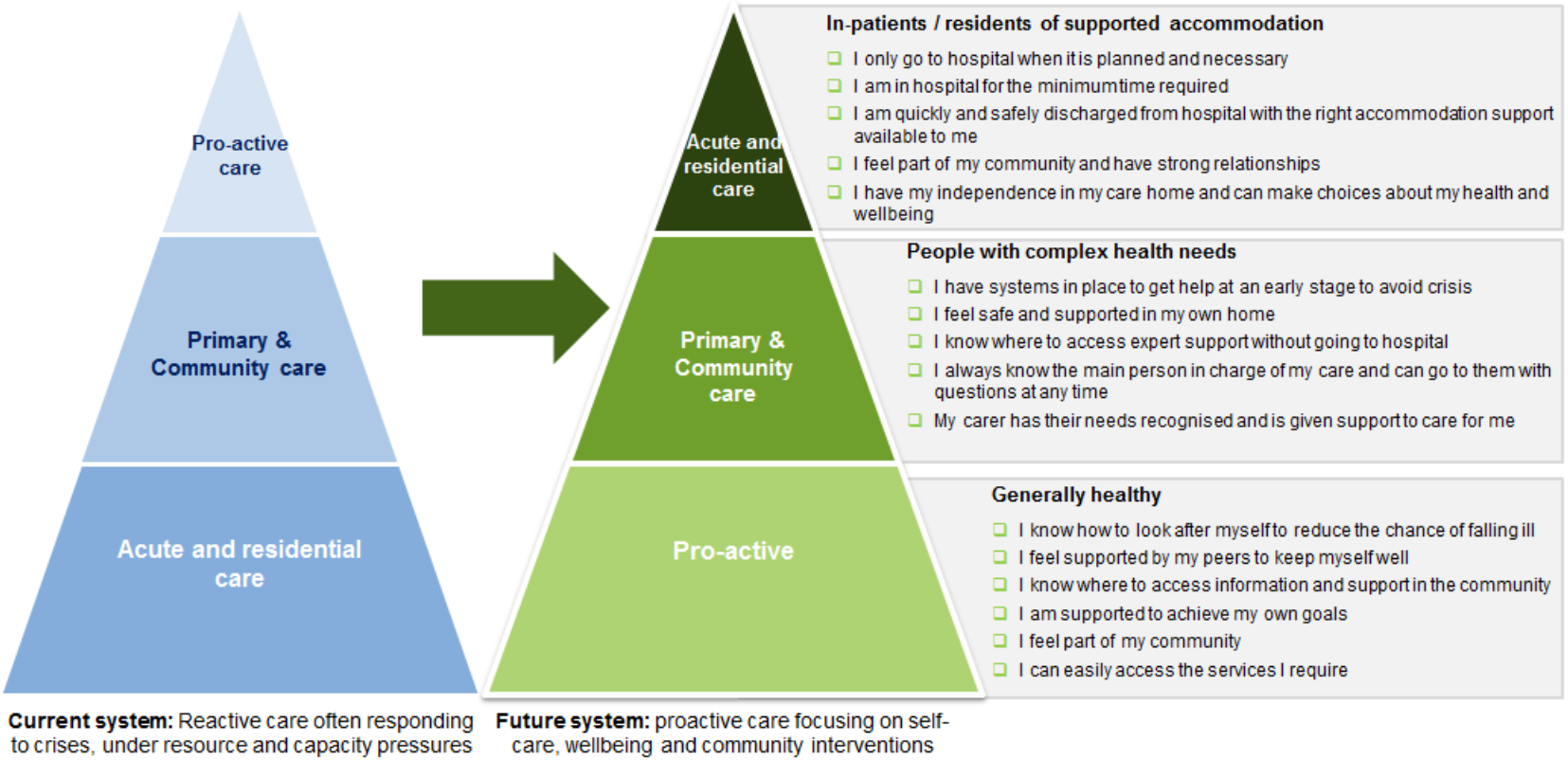
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,00	458,000	26,000	37,900	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	1%	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 b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
	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. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. 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. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. 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	262,000 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. Addressing wider determinants of health 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 can benefit from specialisation and the benefits of senior clinical advice available at most parts of the day. We know from our London wide work on stroke and major trauma that better outcomes can be delivered by consolidating the limited supply of specialist doctors into a smaller number of units that can deliver consistently high quality, consistently 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 acute hospitals are under more strain than ever before. Some of this is due to increasing demand, and our STP sets out how we will manage demand 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. The site 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, meaning that the current clinical model cannot be financially sustainable. 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. 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 and for Charing Cross, 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 host a GP practice and an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs.

The local government position on proposed acute changes is set out in Appendix A.

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 or Hammersmith & Fulham will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

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 £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

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 sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7
Delivery Area (1-5) - Investment	(118.3)	-	-	-	-	-	(118.3)	-	(118.3)
Delivery Area (1-5) - Savings	302.9	120.4	23.0	-	-	-	446.3	62.5	508.8
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0
Other	-	-	-	188.3	-	-	188.3	63.0	251.3
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**
Residual Gap (with application of business rules)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**

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.

Additional savings have been assessed across the five STP delivery areas, and require £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings. These schemes 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 area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for the providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing.

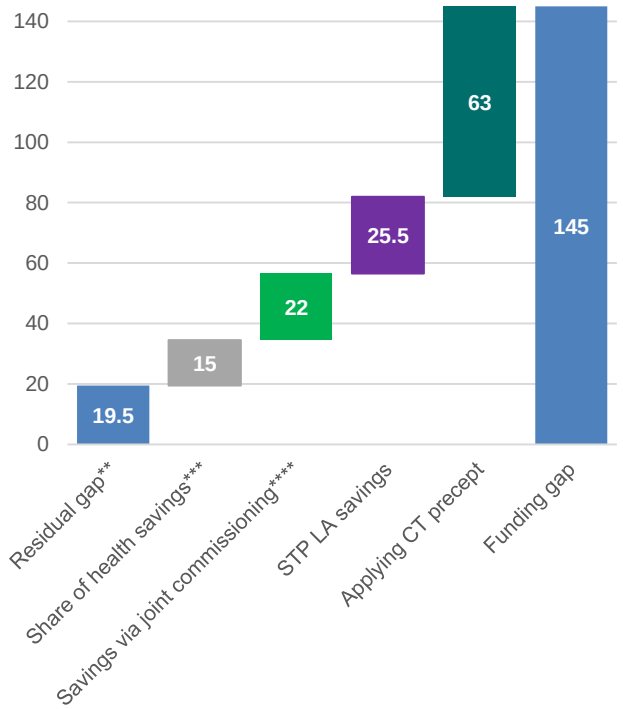
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

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

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. 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 actions set out below describe how the existing gap will be addressed, through 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	-	7.0	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 transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB 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
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. Increased accessibility to primary care through extended hours v. All practices will be in a federation, super practice or on a trajectory to MCP vi. 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. Aiming to move NW London average of 23mins/1000 people to 30mins/1000 people at pace v. Supporting sustainability, reducing unwarranted variation and preparing for Accountable Care Partnerships vi. 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 bank and agency 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]

i. Executive Summary:
How we will make it happen?

To deliver change at scale and pace requires the system to work differently, as both providers and commissioners. We are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. Develop a joint NW London implementation plan for each of the five high impact delivery areas

We will establish jointly led NW London programmes for each delivery area, working across the system to agree the most effective model of delivery and accountable to a new model of partnership governance. We will build on previous successful system wide implementations within Health and Local Government to develop our improvement methodology, ensuring an appropriate balance between common standards, programme management, local priorities and implementation challenges. The standard methodology includes a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. We have also developed a common project 'life cycle' with defined gateways. Models of care are developed jointly to create ownership and recognise local differences and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, seven day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

We are reviewing the total improvement resources across all providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around the delivery areas to increase effectiveness and reduce duplication

We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.

We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.

We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

We are moving towards primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system.

By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements.

By 20/21 we will worked jointly across Health and Local Government to implement Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

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 £1.3bn 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

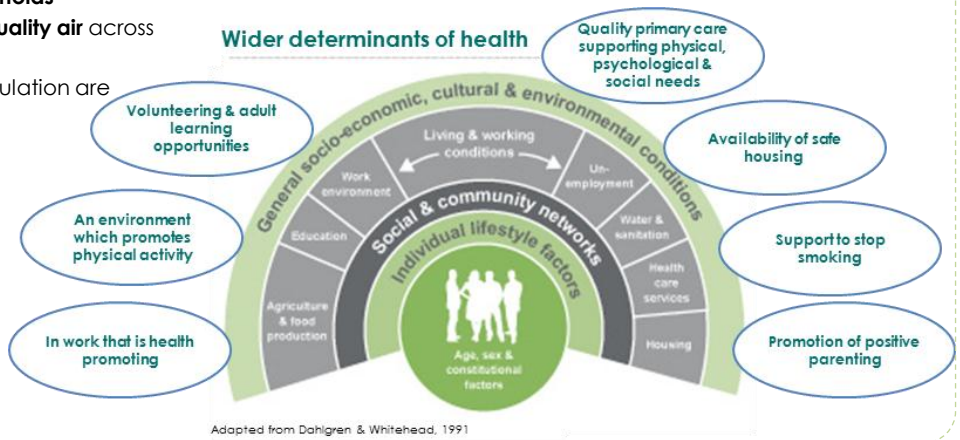
1. Case for Change:
Understanding our population

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
- 36% more adults
- 37% more spend in NW London

Cancer

- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4% 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:
- 1% 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.

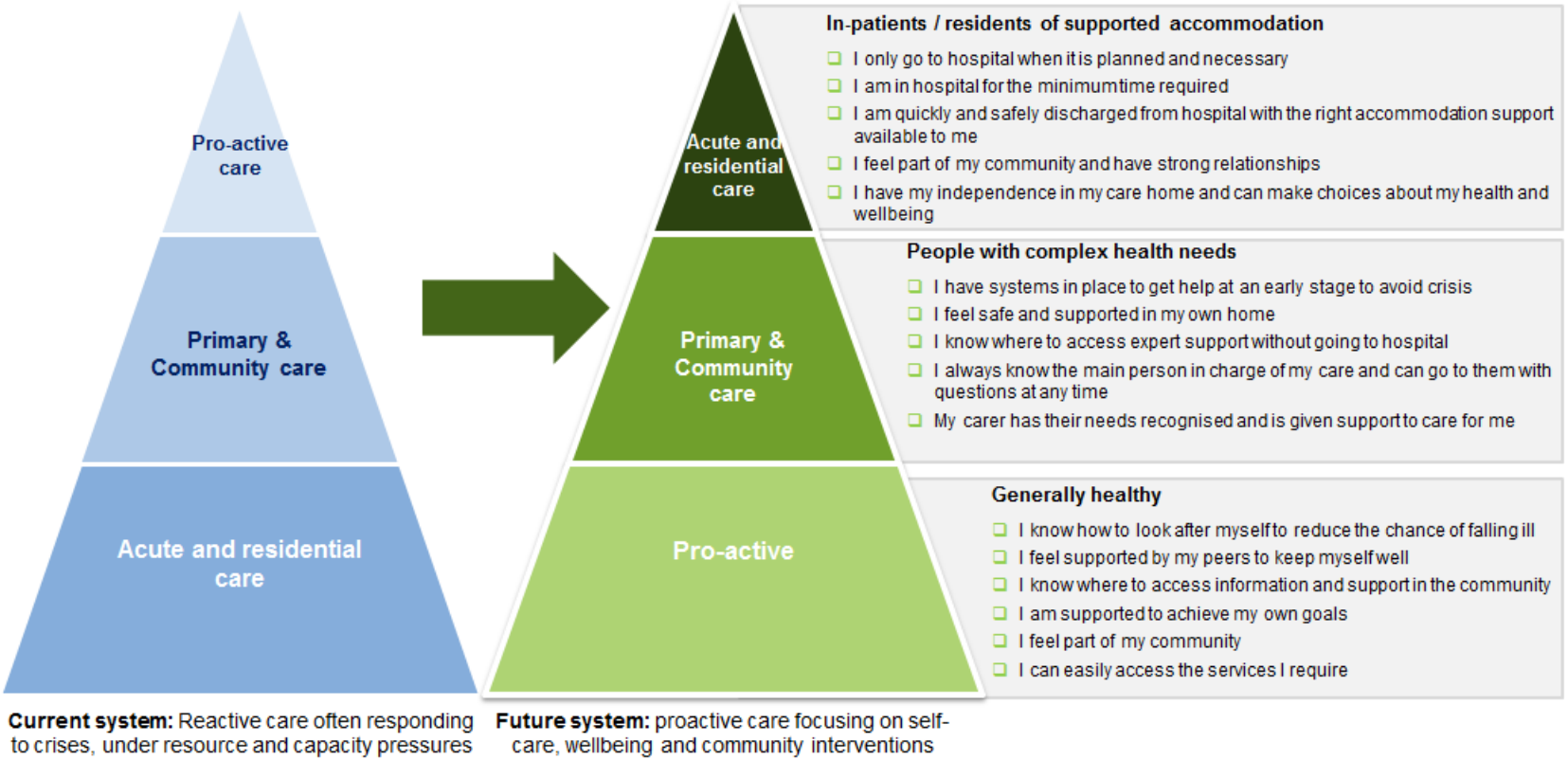
Please note that segment numbers are for adults only with the exception of the children segment

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.

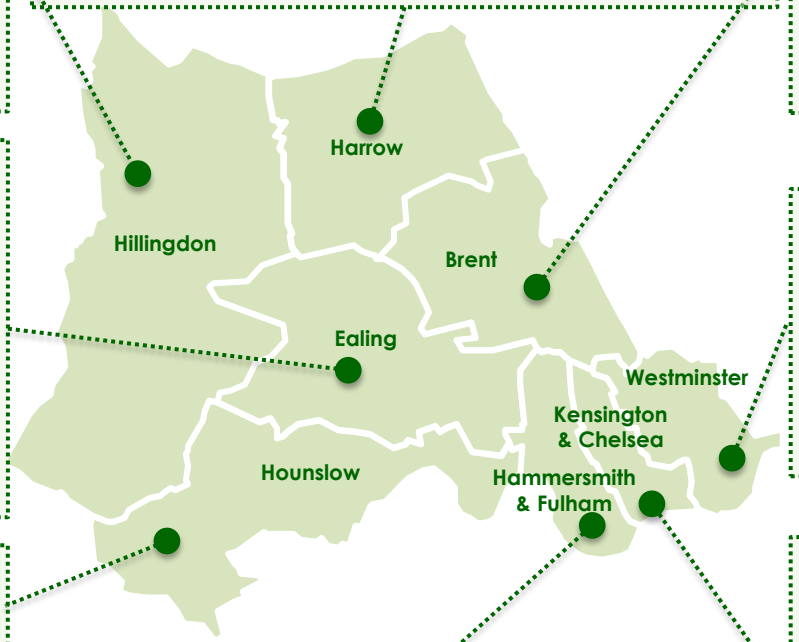
1. Case for Change:
Understanding people's needs

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%

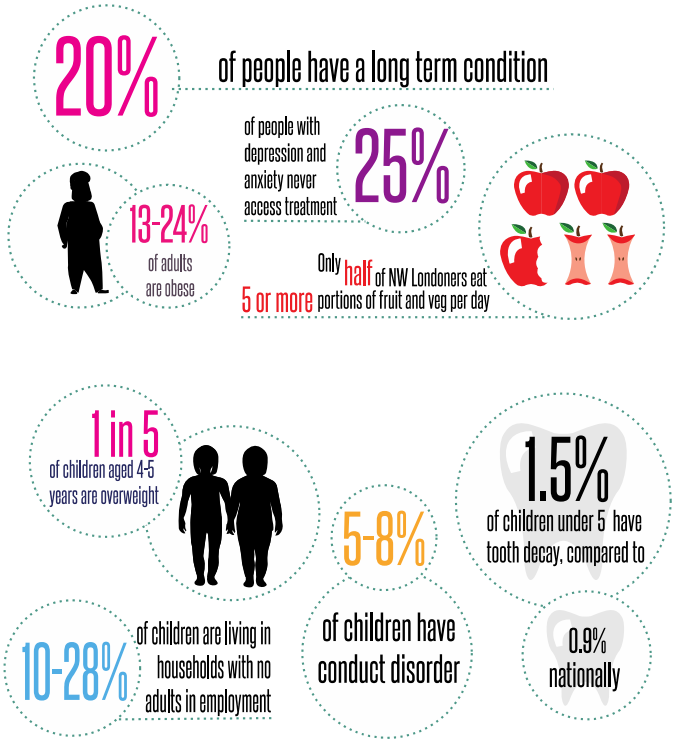
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature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

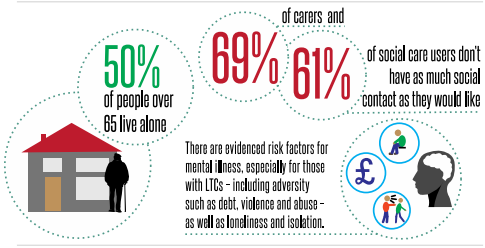
As soon as I am struggling, appropriate and timely help is available

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	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 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated 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 £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

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.

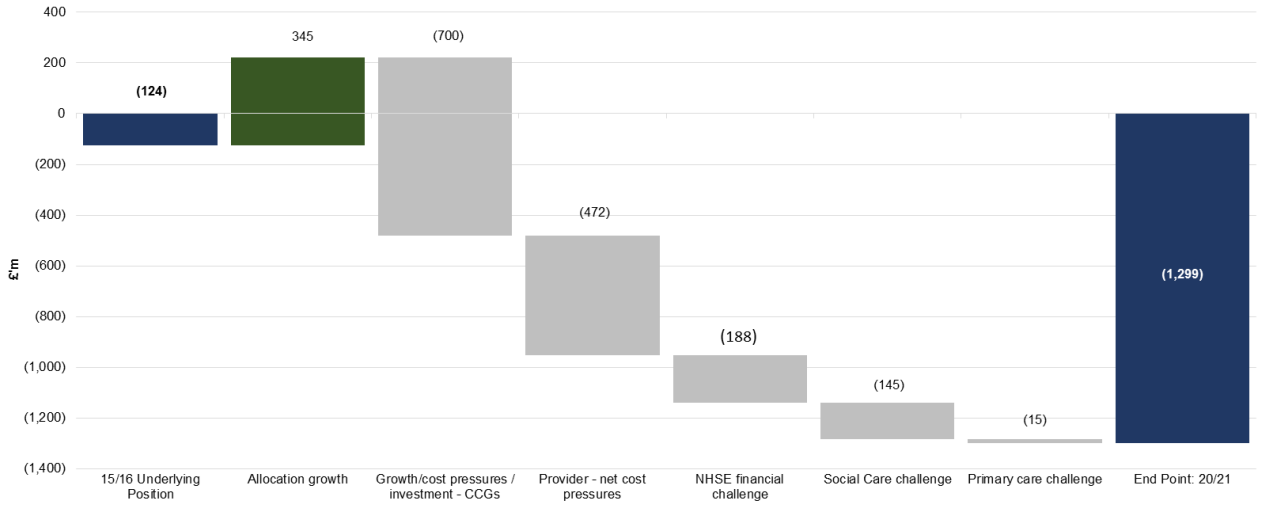


Table 1: Profile of the 20/21 Do Nothing financial challenge by organisation

£'m - Residual Gap	15/16	16/17	17/18	18/19	19/20	20/21
Providers	(190)	(304)	(374)	(462)	(544)	(659)
CCGs	60	(4)	(77)	(140)	(198)	(293)
Specialised commissioning	-	-	(44)	(90)	(138)	(188)
Primary care	-	2	(1)	(12)	(19)	(15)
Total NHS	**(130)**	**(306)**	**(496)**	**(704)**	**(899)**	**(1,154)**
Social Care	-	-	(36)	(73)	(109)	(145)
Total NWL Health and social care	**(130)**	**(306)**	**(532)**	**(776)**	**(1,007)**	**(1,299)**

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 b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
	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. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
	4	Reduce social isolation					
Improving care & quality	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. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. 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	262,000 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. Addressing wider determinants of health 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

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

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

- **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. Our residents who have a learning disability are also sometimes not receiving the fully 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:

- Targeting people at risk of developing long term conditions 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 group includes approximately 120,000 people who are currently well but are at risk of developed an LTC over the next five years[11]. 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].
- Working across the system at both NW London and London level to address the wider determinants of health, such as employment, education and housing.
- 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].
- Focusing on social isolation as a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs. Around 200,000 people in NW London are socially isolated and it 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].

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	Enabling and supporting healthier living	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 NW London Primary Care Cancer Board which will look at improving public messaging/advertising around preventing cancers. Launch a NW London communications and signposting campaign to more effectively guide people to support, including voluntary and community, to improve care and reduce demand on services. As part of this we will: • 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: • Training GPs and other staff in Health Coaching and 'making every contact count' to promote healthy lifestyle choices in patients • Delivering an enhanced 111 service driven by a new Directory of Services which will signpost service users to the appropriate service • Rolling out systematic case-finding to identify and support people at risk of diabetes, dementia or heart disease, using our Whole system IT platform • Promoting a community development approach to improve health by identifying local needs and sign-posting through services, such as, information stalls, children's support sessions, health awareness sessions, debt management and maternity drop-ins • Supporting Healthy Living Pharmacies to train Champions and Leaders to deliver interventions, such as smoking cessation • Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda	0.2	2.5
B	Wider determinants of health interventions	The healthy living programme plans will also cover how Boroughs will tackle wider determinants of health. In 16/17, local government already plans to deliver some interventions, such as: • 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 • Bidding for funds from the joint Work and Health Unit to support social prescribing of employment and interventions for those at risk of losing their employment	As part of the healthy living programme, local government, working jointly with health partners, will take the lead on delivering key interventions by 20/21 such as: • Introducing measures reduce alcohol consumption and associated health risks, e.g. licence controls, minimum pricing and promotions bans • 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 • Partner with organisations such as London Fire Brigade to jointly tackle the wider determinants of health such as social isolation and poor quality housing	3.3	6.5
C	Addressing social isolation	The healthy living programme plans will also cover how Boroughs will address social isolation. 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	As part of the healthy living programme, we will implement key interventions such as: • 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 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.	0.5	6.6

D	Helping children to get the best start in life	• NW London will invest part of its PMS premium income in increasing immunisation rates for key areas of need, such as the 5-in-1 Vaccine by 1 Year
		• Implement the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services
		• Collaborate with the vanguard programme and the children's team at NHSE in the development of new care models for children and young people (C&YP)
		• 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
			• Establish a Connecting Care for Children GP hub in the majority of localities where children live, building on 3 Borough work to:
			  • reduce high outpatient and A&E attendance numbers among C&YP
			  • promote healthy eating and obesity screening pathways (e.g. HENRY)
			  • Co-locating dental professionals and deliver dental hygiene training
			• 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. Unwarranted variation covers all services, from the early detection of cancer, the management of long term conditions, and the length of stay in hospital to the survival rates from cancer and major surgery. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas.
- 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].

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	**Improve cancer screening to increase early diagnosis and faster treatment**	Our Primary Care Cancer Board will take the learning from HLP's 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. We will 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.	Through the Royal Marsden and Partners Cancer Vanguard, develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, thereby reducing variation in acute care and ensuring patients have effective high quality cancer care wherever they are treated in NW London	TBC	TBC
B	**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
C	**Reduce variation by focusing on 'Right Care' priority areas**	Identified and commenced work in 2016/17 in following areas: • Mobilisation of National Diabetes Prevention Programme (commencing August 2016) • Further development of diabetes mentor/champion role within communities • Extend diabetes dashboards to other LTC, improving primary care awareness of variability and performance • Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation • Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD, enabling easy navigation through device-drug-dose considerations and supporting professionals and patients in reaching appropriate decisions and achieving adherence to therapy • 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.	• 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
D	**Improve self-management and 'patient activation'**	• Identify opportunities for patient activation in current LTC pathways based on best practice – application for 43,920 Patient Activation Measures (PAM) licences in 2016/17 for people who feel overwhelmed and anxious about managing their health conditions	• Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be immediately referred into expert patient training • Technology in place to promote self-management and peer support for people with LTCs • Increase availability of, and access to, personal health budgets, taking an integrated personal commissioning approach • PAM tool available to every patient with an LTC to help them take more control over their own care – planned increase in PAM licences to 428,700 • 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 coordinated care and continuity with a named clinician to support them with LTCs	3.4	6.1

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

£82.6m

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 partnership(s) • 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 Partnership(s), 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	Implement new models of local services integrated care to consistent outcomes and standards	• Continue to support the development of federations, enabling the delivery of primary care at scale • Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older person's service and blue print for a NW London model at all hospital sites • Agree and publish clear outcomes for primary care over the next five years • Implement the first elements of the primary care strategic commissioning framework, with a focus in this delivery area on co-ordinated care	• Fully implement the primary care outcomes 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	18	26.3
D	Upgrade 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 • Improve the rate of return on existing services, reducing non elective admissions and reducing length of stay through early discharge • Enhance integration with other service providers	• Use best practise model across all 8 boroughs, creating standardisation wherever possible and investing £20-30m additional funding, including through joint commissioning with local government, creating additional capacity to enable people to be cared for in less acute settings, • Operate rapid response and integrated care as part of a fully integrated ACP model	20	64.9
E	Create a single discharge approach and process across NW London	• Implement a single NHS needs-based assessment form across all community and acute trusts, focusing on discharge into non bedded community services 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 discharge across NW London • Integrate the NHS and social care processes to form a single approach to discharge	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • 100% of discharge correspondence is transmitted electronically; and the single assessment process for discharge is built into the shared care records across NW London • Fully integrated health and social care discharge process for all patients in NW London	7.4	9.6
F	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

Target Population:

262,000

2020/2021

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. But we know that 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.

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 handicapped by their condition and **10% will die by their own hand**.
- 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 you are 18.
- The number of people with serious and long term mental health needs in NW London is double the national average
- 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 – access points and pathways are generally clear and well structured; the same cannot be said for mental health services which can be over-complicated and confusing.

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

- Implementing a new model of care for people with serious and long term mental health needs, 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 wider determinants of health and how they relate to and support recovery for people with mental health needs
- 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
- 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. This includes Future in Mind and Transforming Care Partnerships work.

- 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 – 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 (investment of c£12-13m)
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
			• Full roll out of the new model across NW London, including:
			  • 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
			• **The benefit to the patient will be tailored evidence based support available closer to home**
			 
				11	16

B	**Addressing wider determinants of health, e.g. employment, housing**	• 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	• 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 • **The benefit to the patient will be a happier, fuller way of living**	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) LAS, Metropolitan police and other services – meeting access targets • Round the clock mental health teams in our A&Es and support on wards, 'core 24' • Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)	• 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 • **The benefit to the patient will be care available when it is most needed**	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 • 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 <u>important</u> 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
- Consolidate acute services onto five sites (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham– see Appendix A, condition 5).
- 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	Reduce demand for acute services through investment in the pro active out of hospital care model. Work jointly with the council at Ealing to develop the hospital in Ealing and jointly shape the delivery of health and social care delivery of services from that site, including: • a network of ambulatory care pathways; • a centre of excellence for elderly services including access to appropriate beds; • a GP practice; and • 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.	33.6	89.6

D	NW London Productivity Programme	Implement and embed the NW London productivity programme across all provider trusts, focusing on the following four areas:
		• **Patient Flow**: address pressure points in the system that impacts on patient flow, patient experience and performance against key targets (e.g. 4 hour wait and bed occupancy).
		• **Orthopaedics**: mobilise and commence work around establishing 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).
		• **Procurement**: assuming no mandation of the new NHS procurement operating model, establish the necessary enablers for collaboration to take forward sector-wide transformation in procurement and implement the Carter Review recommendations across the STP footprint[8]. These include establishing line of sight of sector-wide savings opportunities through agreed baseline reporting and on-going measurement of the benefits from collaborations, sector-wide visibility of contracts and establishing governance links to enable wider benefit of existing purchasing collaboratives (e.g. Shelford Group).
		• **Bank & Agency**: reduce agency spend across NW London; initiation of a range of workforce activities such as standardised pay and sector-wide recruitment. The sector is expected to reduce agency spend by £46m and deliver net savings of £32m.
			Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together through ACPs to constantly innovate and drive efficiency. Rolling programme of pathway redesign and patient flow initiatives to ensure trusts are consistently in the top quartile of efficiency. 17/18 plans against the initial delivery areas are set out below:
			• **Patient flow:** Implement system level initiatives in areas such as: improving access to GPs, better management of increasing volumes of ambulance attendances, integrated discharge processes from hospital and best practice A&E processing of patients.
			• **Orthopaedics:** Implement orthopaedics best practice based on Getting it Right First Time. Hip and knee replacements initial area of focus with estimated savings in the region of £2.6m to £4.0m across NW London, then roll out in full.
			• **Procurement:** 2016/17 will establish baselines enabling additional quantified benefits from 2017/18 onwards. Early impact areas include utilities, waste management, agency (linked with Bank & Agency workstream) and applying the GIRFT principles to commoditised purchasing for specific clinical areas.
			• **Bank & Agency:** build on work from 2016/17 , linking with South West London to share best practice. Key areas of focus are
			  • Strengthening recruitment to reduce vacancies
			  • Optimising scheduling to reduce demand
			  • Shifting usage from agency to bank to reduce costs
			  • Reducing unit costs for agency by increasing use of framework agencies and reducing rates through volume based contracts
				4.1*	143.4

*This is investment in the Delivery Architecture to achieve cross-provider CIPs – see Section 6

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 move more services into a community setting
- 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
- **Improving and changing our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care

Digital will…

- Deploy our **shared care record** across all care settings to improve care, reduce clinical risk, and support transition away from hospital
- **Automate clinical workflows and records** and support transfers of care through **interoperability**, delivering digital empowerment by removing the reliance on paper and improving quality
- **Extend patient records to patients and carers** to help them to become more digitally empowered and involved in their own care, and supporting the shift to new channels
- Provide patients with **tools for self-management and self-care**, further supporting digital empowerment and the shift to new channels
- Use **dynamic data analytics** to inform care decisions and target interventions, and support integrated health and social care with whole systems intelligence

Workforce will…

- **Targeted 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.
- NW London has the opportunity to work across health and local government, promoting the 'One Public Estate' 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.
- Some progress has been made 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 £623m[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, due by end 2016
  - The hub strategy and plans include community Mental Health services, such as IAPT
- **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 – see Appendix A, condition 5).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local population
  - Trusts are currently developing their site proposals, which will feed into an overall N W London ask for capital from the Treasury, contained in the strategic outline case to be submitted this summer.

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:

- Local services hubs will provide the physical location to support prevention and out-of-hospital care.
- 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 7/7 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 inpatient 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

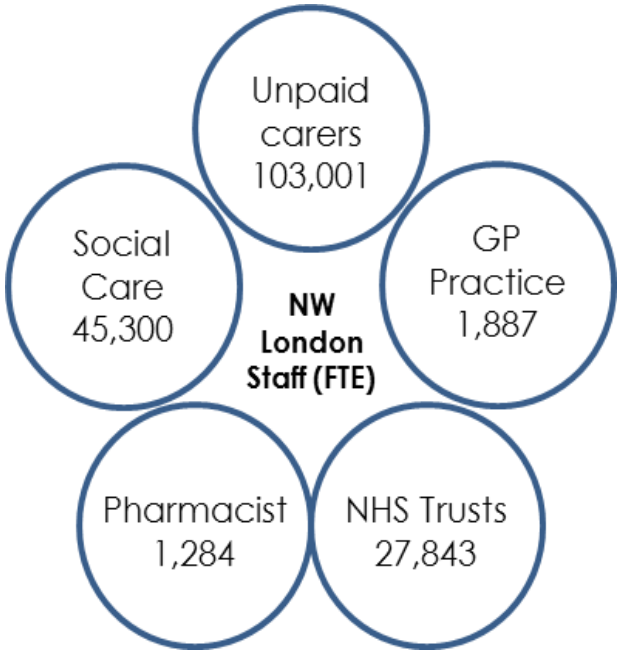
Delivery Area 5 – Providing high quality, sustainable acute services:

- 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: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work and will be key to achieving our collective vision through delivering sustainable new models of care to deliver improved quality of care that meets our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. Carers are 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. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly expand work across social care[1].
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- Appropriate workforce planning and actively addressing workforce issues is instrumental in addressing the five delivery areas in the STP
- 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.
- 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, with 32 commencing training in September. 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, 36 more paediatric nurses (37 more commence in September '16) and 3 consultants paediatricians (6 appointed to start in September '16, with plans to recruit 3 more).
- Building on this track record, **key enablers** will include the collaborative and partnership working between CCGs, Trusts, HEENWL and the CEPNs (Community Education Providers Network) to support workforce planning and development, and the HLP to utilise the established workforce planning infrastructure and expertise, build on strong foundations of on-going strategic workforce investment, and embed the findings outlined in HLP's London Workforce Strategic Framework.



What will be different in 2020[6]?

Our workforce strategy will address the following challenges 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

Current Transformation Plans and Benefits

Addressing workforce shortages

- Through workforce planning and extensive stakeholder engagement NW London is understanding and addressing key workforce issues. For example, NW London is leading a centralised Pan-London placement management and workforce development programme for **paramedics** with an investment of over £1.5m

Improving recruitment and retention

- NW London has plans to step up recruitment. For example, by October 2016, there is planned recruitment of over 100 additional **nursing staff** and 7 additional **children's consultant medical staff** leading to more senior provision of children's care. Further initiatives include:
  - **Scale recruitment drives**; leveraging the benefits of working in NW London.
  - Development of varied and **structured career pathways** and opportunities to **taper retirement**.
  - **Skills exchange** programmes between nurses across different care settings.
- **Promoting careers in primary care** by providing student training placements across professions to introduce this setting as a viable and attractive career option.
- Supporting the **implementation of 7 Day Services** by designing a framework to support career development and retention in radiology. Addressing workforce shortages will also support the development of the Cancer Vanguard.
- A **structured rotation programme** will support 200 nurses to work across primary and secondary care (including key areas such as mental health and care of the elderly).
- NW London's trusts will work collaboratively to **reduce reliance on agency** nurses (current spend: £172m pa on bank/agency[7])

Workforce Transformation across health and social care workforce to support integrated care

- Embedding **new roles** to support the system including: Physician's Associates, Care Navigators, Clinical Pharmacists, Peer Educators (support worker that can share experiences of mental health), and Nurse Associates.
- **Hybrid roles and developing career pathways** across health and social care will be important in the long term.
- Significant investment into Dementia, Community and Neonatal Nursing, Apprentices and the bands 1-4 workforce.
- **Optimising GPs' time** by understanding how we can develop the primary care workforce (including **practice manager development**) to redeploy GP workload where possible and increase the capability to deliver the business requirements of GP networks(Day Of Care Audit).
- **Supporting self-care** through use of patient activation measurements and Health Coaching training to help staff to have motivational conversations with patients, to empower them to set and achieve health goals, take greater responsibility for their health, and grow in confidence to self-manage conditions

Leadership and Organisational Development to support future services

- **Collective, system leadership**, will be key to the success of ACPs. Leadership development will be broader than senior leadership level; empowering MDT frontline practitioners to lead and engage other professionals and take joint accountability across services will be integral to success.
- Leadership and change management programmes will foster innovation, build relationships and trust across multi-disciplinary, cross organisational teams to deliver integrated new ways of working. The **Change Academy** will use an applied learning approach and will be underpinned by improvement methodology (38 leaders supported in phase 1)
- **Commissioning for outcomes** based programmes
- Leadership development forums will include the **GP Emerging Leaders** (providing NW London-wide workshops, mentoring, and sharing of local intelligence and education) and Transformation Network
- More effective ways of working achieved through the **Streamlining London Programme** across Trusts
- Adopting a collaborative approach to embed **health and wellbeing initiatives and ambassadorship** through the Healthy Workplace Charter

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:

- **Health Coaching** training will help staff to have motivational conversations with patients to take greater responsibility for their health, and grow in confidence to self-manage conditions.
- To ensure carers, the largest proportion of our workforce, are supported, we will expand the programme in 2017/18, to build carers' skills around setting achievable health and wellbeing related goals for patients.
- The NW London **Healthy Workplace Charter** will embed staff health and wellbeing initiatives and ambassadorship
- Primary care and specialist community nurse workforce development

Delivery Area 2 - Reducing variation:

The framework to retain staff and support career development in radiology will help address shortages and support **implementation of 7 Day Services** and **Cancer Vanguard**. Growth in primary care and bespoke project work on LTCs prevalent in NW London such as diabetes and heart disease.

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
- **Optimising GPs' time** by developing the primary care workforce (e.g. **practice manager development**) will increase capability to deliver the business requirements of GP networks
- Leadership development forums will join up practitioners, providing NW London-wide workshops, opportunities to network and share local intelligence
- 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 will graduate in June 2016 with an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.

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 and thereby the cost of service
- The **Change Academy**, underpinned by improvement methodology and alignment to achieving productivity gains will support cross-boundary working and support financial sustainability of services.

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London Informatics, and has made good progress with Information Governance across care settings. All of the eight CCGs have a single IT system across their practices and six of the eight CCGs are implementing common systems across primary and community care, and have a good track record in delivery of shared records, for example, through the NW London Diagnostic Cloud.
- The NW London Care Information Exchange is under way, funded by Imperial College Healthcare charity. This technology programme gives individuals a single view of information about their care across providers and platforms, allows sharing of information, and provides 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.
- There is good support from NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London exchange, record locator, and IG register.

Key Challenges

- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access and retain information about the patient[1]. A potential mitigation is to share care records and converge with other Local Digital Roadmaps (LDR) via universal NHS systems.
- Due to different services running multiple systems, there is a dependence on open interfaces to deliver shared records, which primary and community IT suppliers have failed to deliver. This will require continued pressure on suppliers to resolve.
- 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 required from NHSE to define and fund interfaces nationally.
- Clinical transformation projects have in the past been very costly and taken a long time to deliver, which need to be allowed for in the LDR plans
- There is a lack of digital awareness and enthusiasm generally among citizens and professionals, requiring a greater push for communication around the benefits of digital solutions and education on how best to use it.

Strategic Local Digital Roadmap 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. **Extend patient records to patients and carers,** to help them to become more **digitally empowered** and 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 care, further supporting **digital empowerment** and the shift to new channels of care
5. **Use dynamic data analytics** to inform care decisions, and support integrated health and social care across the system 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**, where much work has already been done
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education

3. Enablers: Digital

STP Delivery Area	Digital STP Theme	Key Impacts on Sustainability & Transformation Planning
1. Radically upgrading prevention and wellbeing	• Deliver digital empowerment • Integrate health & care records	**Enhancing self care:** • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange** to support them to become expert patients • Innovation programme to find the right **digital tools** to help people **manage their health and wellbeing**; **create online communities** of patients and carers; and to get children and young people involved in health and wellness **Embedding prevention and wellbeing into the 'whole systems' model:** • Support integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care-plans)
2. Eliminating unwarranted variation and improving LTC management	• Integrate health & care records • Whole systems intelligence • Deliver digital empowerment	**Improving LTC management** • Deliver Patient Activation Measures (PAM) tool for every patient with an LTC to promote self management and develop health literacy and expert patients • **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability and development of a share care record to deliver the **integration of health and care records and plans** • Patient engagement and self-help training for LTCs to help people manage their conditions and interventions **Reducing variation** • Integrated care dashboards and analytics to track consistency of outcomes and patient experience • Support new models of multi-disciplinary care, delivered consistently across localities, through shared care records
3. Achieving better outcomes and experiences for older people	• Deliver digital empowerment • Integrate health & care records • Whole systems intelligence	**Provision of fully integrated service delivery of care for older people** • Enable citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange**, **remote consultations** (e.g. videoconferencing) and **telehealth** • Support discharge planning and management, new models of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care • **Integrate Co-ordinate My Care** (CMC) with acute, community and primary care systems and promote its use in CCGs, where usage is currently low, through education and training and support care planning and management • **Shared information and infrastructure** to support new primary care and wellbeing hubs with mobile clinical solutions • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care dashboards have been deployed to 312 GP practices to support co-ordinated and proactive patient care, with a plan to expand to all 400 practices by 2020/21
4. Improving outcomes for people with mental health needs	• Integrate health & care records • Whole systems intelligence	**Enabling people to live full and healthy lives** • Innovation programme to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities **New model of care** • Support new care delivery models and shared care plans through **shared care records and care plans** **24/7 provision of care** • Support new models for out-of-hours care through **shared care records**, such as **24x7 crisis support services**
5. Ensuring we have safe and sustainable acute services	• Deliver digital empowerment • Integrate health & care records	**Investing in Hospitals** • Support new models for out-of-hours care through **shared care records and the NW London diagnostic cloud**, such as 24x7 on-call specialist and pan-NW London radiology reporting and interventional radiology networks in acute • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Integrated out-of-hours **discharge planning and management** through shared care records • **Dynamic analytics** to track consistency and outcomes of out-of-hours care

4. Primary care in NW London

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. GPs are not only the first point of contact for the majority of residents, but also play a co-ordinating role throughout each patient's journey through a range of clinical pathways and provider organisations.

There are, nevertheless, significant challenges. These include:

- dramatic projected increases in the number of older people presenting with multiple and complex conditions, fuelling demand for GP appointments and a greater co-ordinating function within primary care – the number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26;
- 27.1% of the GP and nurse workforce is aged over 55 and 7.4% aged over 65, which represents a significant retirement bubble;
- front-line delivery pressures that are contributing to recruitment and retention challenges, whilst lowering the morale of GPs and their primary care colleagues; and
- inadequate access to primary care, contributing to a patient-reported experience of GP services significantly below the national average.

These and other challenges require fundamental changes to the design and delivery of primary care, within the context of NW London's broader system transformation across health and social care. The NW London CCGs' plan for this is described in this document.

Some other statistics: achievements and challenges

- The NW London CCGs score above the London average for 6 out of 7 facets for co-ordinated care, based largely on the achievements made through the Whole Systems Integrated Care national pioneer programme
- The NW London CCGs score above the London average for 6 out of 13 facets for accessible primary care consultations (including telephone, email, and video consultations)
- 23% of the NW London practices so far inspected by the CQC ratings are performing below the national average
- 60% of people with a long-term condition feel supported to manage their condition – below the national average of 67%.

Some of our achievements so far

- NW London is the largest national pilot site for the Prime Minister's Challenge Fund, covering 365 practices and 1.9m people. This investment has improved patient access to general practice and supported the development of at-scale organisations in primary care. The CCGs are now working with NHS England to build on this achievement through the new Prime Minister's Access Fund investment announced in the GP Forward View.
- 280,000 patients can access web-based consultations .
- 60,000 patients can access video consultations.
- 97% of practices offer online appointment booking.
- Joint co-commissioning is embedded in NW London . Over recent months each joint committee has agreed its PMS review commissioning intentions, as a first instalment to equalising the patient offer in each CCG, and recommended estates bids to the Estates and Technology Transformation Fund
- Integrated care data dashboards have been piloted in eight practices, with a rollout plan prepared for 350 practices within 12 months. The dashboards link the past two years of patient-level data from acute, primary, community, and mental health, enabling patient journeys through the health system to be tracked and their care to be improved where appropriate.
- Contracts covering 19 services have been let at federation-level across five of the eight CCGs enabling a consistent service offering to the whole population.

Additional work already under way

- CCG self-care leads and lay partners across NW London have co-produced a self-care framework. This includes patient activation measurement that is to be piloted in approximately 200 GP practices by March 2017.
- 180 Healthy Living Pharmacies have been commissioned for 2016/17. They will train Health Champions and Healthy Living Pharmacy Leaders to support local communities with wellbeing interventions such as smoking cessation.
- Hillingdon and Ealing CCGs are providing a Minor Ailments Scheme, allowing patients to self-medicate when appropriate, reducing the impact on primary care. We plan to roll this scheme out across NW London by 2018/19.
- 32 Physician Associates places have been commissioned at Buckinghamshire New University and Brunel University, starting later in 2016.
- The Clinical Pharmacists in General Practice pilot is underway at 23 GP practices in NW London .
- The CCGs plan to make seven collective technology bids to the Estates and Technology Transformation Fund. These will cover areas including digitally-enabled patients, videoconferencing, integrated telecoms and patient management systems, and care home pilots.
- On-going work on local implementation of the 10 Point Plan for workforce includes: a recruitment evening session at Northwick Park Hospital for Foundation Year Doctors, the national thunderclap campaigns organised by HEE, and Joint work with the Foundation School and Medical School to attract new GP Trainers into local training programmes.

4. The future of primary care in NW London

NW London has a clear set of primary care outcomes that the CCGs will support providers to deliver over the next five years. These are shown below, along with how they map onto the five delivery areas to illustrate the crucial role that primary care has in delivering the NW London STP.

- Radically upgrading prevention and wellbeing
- Ensuring we have safe, high quality sustainable acute services
- Eliminating unwarranted variation and improving LTC management
- Achieving better outcomes and experiences for older people
- Improving outcomes for children and adults with mental health needs

Proactive care	
Co-design	- primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population
Developing assets and resources for improving health and wellbeing	- primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community
Personal conversations focused on an individual's 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	- primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
Patients not currently accessing primary care services	- primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

Accessible care	
Patient choice	- patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs
Contacting the practice	- patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations)
Routine opening hours	- patients can access pre-bookable routine appointments with a primary health care 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 seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments
Same-day access	- patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network
Urgent and emergency care	- patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately
Continuity of care	- all patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate

Co-ordinated care	
Case finding and review	- practices identify patients, through whole systems data analytics, who would benefit from coordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis
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 their 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 through health coaching, future digital tools and other forms of education
Multi-disciplinary working	- patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer. Care will be coordinated via shared electronic care records.

4. Delivering the ambitions of the primary care strategy

Following the NW London-wide development of ambitions and outcomes for primary care, the CCGs are now working with primary care providers to agree how this will be delivered in each borough in a way that meets the needs of their local populations. The draft process is shown below. This will be the basis of the design and delivery of annual commissioning intentions each year until 2020/21, with delivery of the SCF achieved by the end of 2018/19.

This will ensure that the increases to the NW London primary care medical allocations (shown in the table below) are invested in a way that delivers maximum benefits to patients, alongside the national programmes – such as the Prime Minister's Access Fund, from which NW London might be able to access approximately £12m in 2016/17 – announced in the GP Forward View.

NW London CCGs	2016/17	+£19.3m	2017/18	+£11.8m	2018/19	+£11.5m	2019/20	+£15.6m	2020/21
	£279.97m		£299.26m		£311.03m		£322.50m		£338.07m

SCF implementation

2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21

June, July

A two-month collaborative process led by CCGs and supported by the Local services team to define each CCG's model of care.

The primary care component will include the outcomes and ambitions set out above.

August

The CCG primary care teams will, with the Local services team, then:

- undertake a gap analysis;
- translate the gaps into high-level prioritised annual commissioning intentions to 2020/21, based on confirmed allocations; and
- form a detailed plan for the design and implementation of 2017/18 priorities.

The Local services team will work with CCGs to design a standard process and format for this.

September

Governing bodies sign off:

- local model of care
- gap analysis
- prioritised annual commissioning intentions to 2020/21, based on SCF implementation by April 2019
- a detailed plan for the design and implementation of 2017/18 priorities, including business case and governance

The Local services team develops a pan-NW London plan to April 2017 to support consistency and alignment / 'develop and spread', based on detailed CCG plans and accounting for dependencies with enablers.

CCGs and the Local Services team will report on progress against this plan to the Local Services programme executive.

Shared CCG materials

HLP SCF costing and impact analysis

National programmes based on the GP Forward View and local programmes funded by the Sustainability and Transformation Fund

A **recurring annual cycle of primary care commissioning**: engagement, confirmed commissioning intentions, business case development, detailed planning, and implementation, based on the model of care and prioritisation approved by the governing body in September 2016.

Commissioning intentions that directly support the SCF will be prioritised before April 2019.

SCF commissioning intentions

SCF+ commissioning intentions

A **recurring annual cycle** of the Local services team building a NW London-wide plan against which all parties will report progress and be held accountable for delivery.

Support on enablers from Strategy and Transformation and other pan-CCG teams – including **federation development**

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 at an STP level there is a surplus of £50.5m and there is a small, £31m gap to delivering the business rules (i.e. including 1% surpluses).

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care	
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**	**note 1**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7	**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)	(34.0)	(89.7)	**note 4**
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0	**note 4**
Other	-	-	-	188.3	-	-	188.3	63.0	251.3	
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**	
Residual Gap (see note)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**	
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**	
				note 5				**note 3**		

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since April '16 STP due to changes in the underlying position of organisations and social care, inclusion of 1% gap requirement on Trusts, NHSE spec comm gap for the Royal Brompton, removal of 16/17 CIP and the inclusion of Primary Care.

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: The financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

The key financial challenge that remains at 2020/21 is the deficit at the Ealing site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging. This deficit could be eliminated if acute services changes were accelerated, generating a further improvement in the sector position of £62m.

The key risk to achieving sector balance is the delivery of the savings, both business as usual and the delivery areas. There will be a robust process of business case development to validate the figures that have been identified so far and the next section of the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered.

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

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 1% surplus for the NHS.

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.

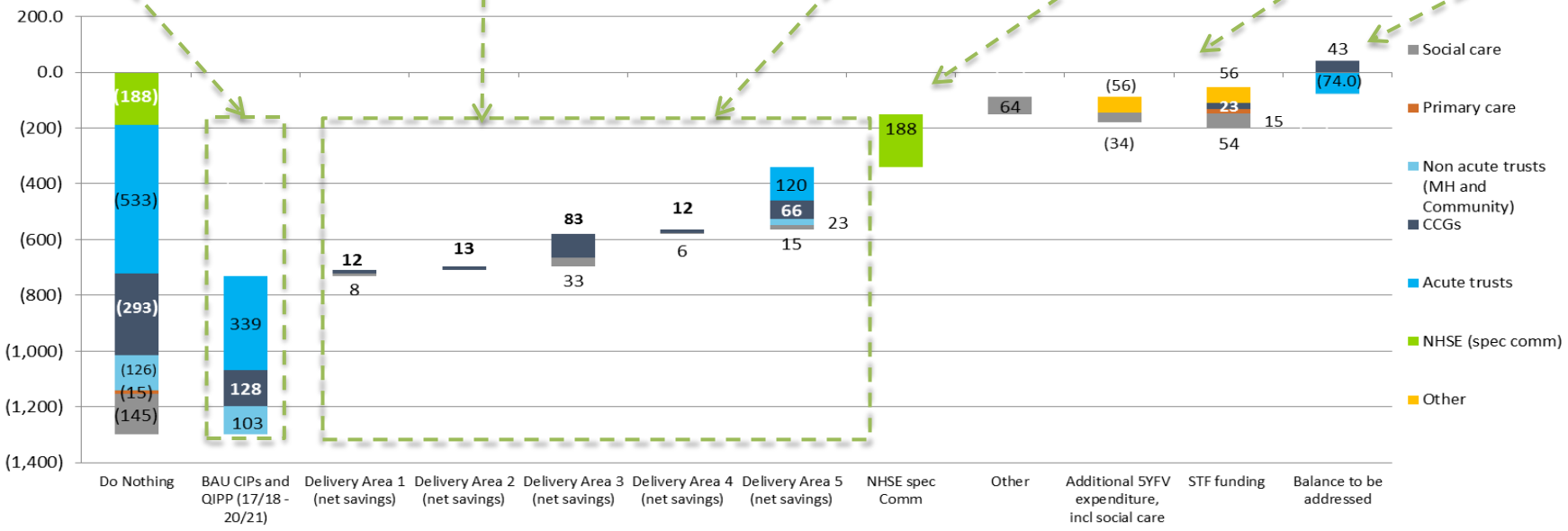
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

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

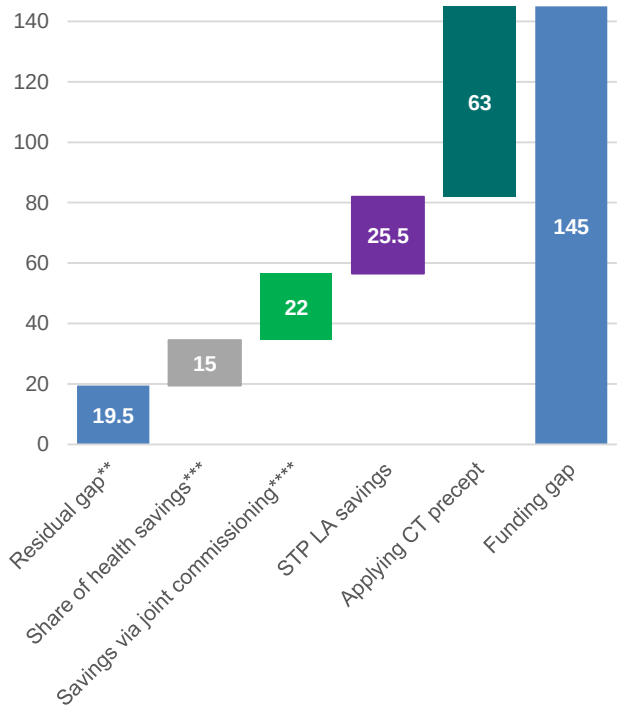
Balance to be addressed Remaining gap of £31m to be addressed – post 20/21.



5. Finance:
Social Care Finances

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. 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 actions set out below describe how the existing gap will be addressed, through 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**	**-**	**7.0**	**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 transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

5. Finance:
STP financial enablers – Sustainability and Transformation Funding

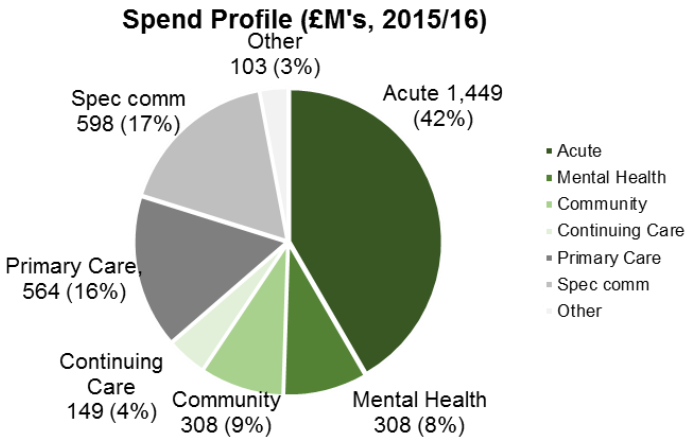
To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. This is set out below, and shows our expectation of where we expect to invest the funding recurrently from 2020/21.

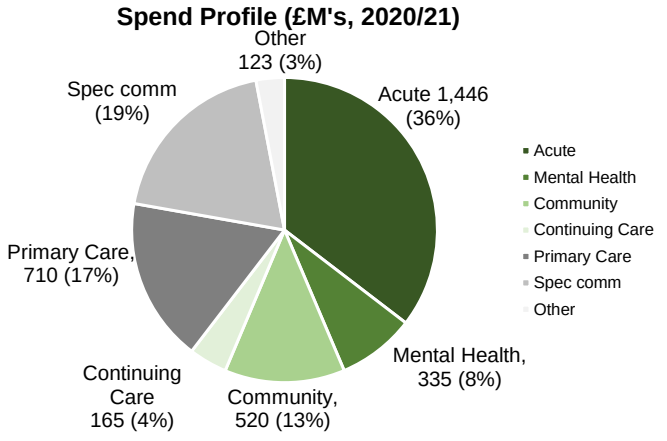
	16/17	17/18	18/19	19/20	20/21
	£m	£m	£m	£m	£m
Sustainability funding	-	112.4	82.3	61.6	0.0
Investment in prevention and social care	-	21.0	25.0	30.0	34.0
Social care funding gap	-	-	-	-	19.5
Seven day services	3.0	4.0	7.0	12.0	20.0
Mental health transformation and invetment in services - integrated care models	0.0	10.0	10.0	13.0	20.7
Federation and primary care development	5.0	10.0	10.0	5.0	0.0
Support new payment models design and implementation	3.0	10.0	10.0	5.0	0.0
Digital roadmap	-	3.0	10.0	10.0	15.0
Improvement resources	2.0	2.0	2.0	0.0	0.0
Additional investment in primary care services	0.0	1.0	12.0	19.0	14.8
Uncommitted funding	0.0	0.0	0.0	0.0	23.0
TOTAL	**13.0**	**172.4**	**156.3**	**136.6**	**147.0**

£53.5m

£55.7m

The charts below show how the delivery of the STP will change the commissioner expenditure profile over the next 5 years as we move from a reactive system to a proactive care model. Acute spend by CCGs reduces from 42% to 36% of total spend, while primary and community care spend increases from 25% to 30%. Mental health spend stays the same as a percentage of the total but the expenditure increases and the way in which the money is spent shifts towards community based rather than acute based interventions, enabling increased demand to be managed. Some increased mental health spend is also included within the main primary care and community expenditure totals.





5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £783m (funded by £573m from internal resources, £37m from disposals and £173m 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 and the subsequent five years. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

Table 1: Do Something Capital

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Gross Capital Expenditure	75.2	247.4	219.2	206.1	**747.9**
Disposals and contingency	-	(330.0)	-	-	**(330.0)**
Total Net Capital Requirements	**75.2**	**(82.6)**	**219.2**	**206.1**	**417.9**
Post 20/21					
Gross Capital Expenditure	252.5	1,116.0	4.5	97.1	**1,470.1**
Disposals and contingency	29.0	(681.2)	23.0	-	**(629.2)**
Total Net Capital Requirements	**281.5**	**434.8**	**27.5**	**97.1**	**840.9**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: Projected costs, land sale receipts and affordability, particularly in the second five year period, are indicative and subject to detailed business case processes

Other Additional Capital – there are additional capital cases of £303m made up of: (1) £141m for LNWH for additional investment in NPH and CMH including, ICT and EPR and other IT; (2) £53m for backlog maintenance for THH relating to the tower; (3) £79m for CNWL for strategic developments; and (4) ETTF IT Digital roadmap of £31m.

To address the sustainability challenge at Ealing hospital would require the acceleration of the capital developments and approvals process (within the 'Outer NWL'. If that were achieved the capital profile would change, with the estimated position shown below :

Table 2: Accelerated timeline

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Total Net Capital Requirements	**249.9**	**(82.6)**	**219.2**	**206.1**	**592.6**
Post 20/21					
Total Net Capital Requirements	**106.8**	**434.8**	**27.5**	**97.1**	**666.1**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: The table shows the re-phasing without any assumed inflation saving (estimated to be c. £30m)

The funding for above capital ask will be a mixture of loans and PDC, which will modelled within individual business cases.

6. How we will deliver our plan:
Our NW London Delivery Architecture

To deliver this change at scale and pace will require the system, us, to work differently, as both providers and commissioners. At its heart, this requires shared commitment to an agreed vision, a credible set of plans and the right resources aligned to those plans. We know this both from the literature but more critically through our own experiences and track record of delivery change. Therefore we are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. **Agree a joint NW London implementation plan for each of the 5 high impact delivery areas**
2. **Shift funding and resources to the implementation of the five delivery areas, recognising funding pressures across the system and ensure we use all our assets**
3. **Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities**
4. **Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital**

1. Develop a joint NW London implementation plan for each of the 5 high impact delivery areas

We will set up or utilise an existing joint NW London programme for each delivery area, working across the system to agree the most effective model of delivery. We have built upon previous successful system wide implementations to develop our standard NW London improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges. This has been codified in the common project lifecycle, described below, with common steps and defined gateways:

Critical success factors of the standard methodology include a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. Models of care are developed jointly to create ownership and recognise local differences, and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, 7 day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures and complementary skills across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

- We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.
- We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.
- We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

To further support the alignment of resources we are mapping and reviewing the total improvement resources across all providers and commissioners, including the AHSN, to realign them around the delivery areas to increase effectiveness and reduce duplication. The diagram on the next page also indicates where the various delivery areas are being supported:

NW London Collaboration of CCGs Strategy & Transformation Team *Commissioner* ~ 80-100 staff	**West London Alliance Local Government** Work in progress to allocate key L G staff	**Academic Health Sciences Network (Imperial College Health Partners)** AHSN ~ 8 staff	**Provider Transformation/ Productivity (CIP)/ Integration Teams** *Providers* ~ 90 staff
DA1 a) Enabling and supporting healthier living			Business as usual CIP
	DA1 b) Wider determinants of health interventions		DA2 c) Delivering 'Right Care' priorities
	DA1 c) Helping children get the best start in life		DA4 c) Crisis support and Crisis Concordat
DA1 d) Addressing social isolation			DA5 a) Specialised Commissioning
DA2 a) Improving cancer screening			DA2 a) Improving cancer screening
DA2 b) Better outcomes and support for people with common MH			DA5 b) Delivering the '7 day standards'
DA2 d) Improving self management and patient activation			DA5 c) Configuring acute services
DA3 a) Improving market management and whole systems approach			DA5 d) NW London provider productivity programme
DA3 b) Implementing Accountable Care Partnerships (ACPs) by 2018/19			
DA3 c) Implement new models of local services			
DA3 d) Upgrade rapid response/IC services			
DA3 e) Creating a single discharge process			
			DA3 f) Improving last phase of life
DA4 a) New model of care for people with serious and long term mental health needs			
DA4 b) Addressing wider determinants of health			
DA4 d) Implement Future in Mind			
DA5 b) Delivering the '7 day standards'			
DA5 c) Configuring acute services			

Over time, we are seeking further alignment and integration between these teams, to avoid duplication and align the relevant people and skills to the most appropriate programmes of work

6. How we will deliver our plan:
Our NW London Delivery Architecture

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board which would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

- We are moving towards federated primary care primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system
- By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements
- By 20/21 we will have implemented Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

Latest progress with the provider productivity programme

Providers in NW London have been collaborating to identify productivity opportunities from joint working, building from the recent Carter Review. These opportunities are detailed in the STP. Current progress is focused on mobilising a joint delivery capability across the providers, and then mobilising for delivery the priority projects of:

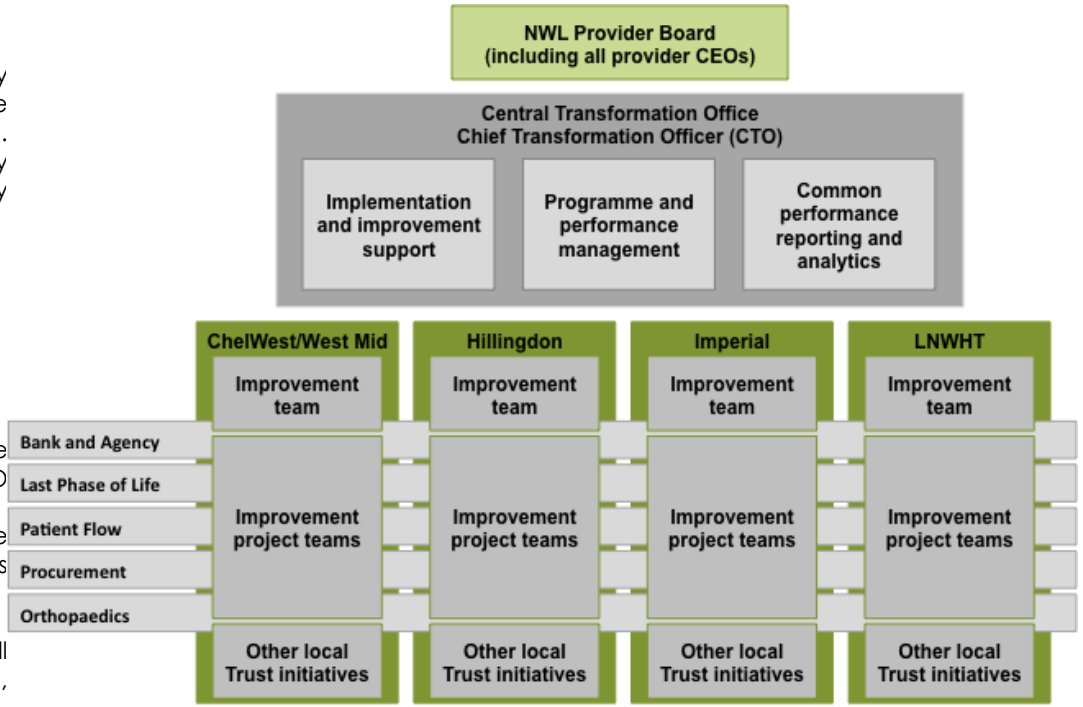
- Bank and agency
- Orthopaedics
- Procurement
- Patient flow

The schematic on the right sets out the end state.

To achieve this providers are working together to:

- Recruit a sector transformation director to lead the programme, with analytics funded by CCGs and PMO provided by ICHP.
- Programme directors are now in place for all but one programmes, programme directors and project managers funded by acute trusts.

As a result savings are expected in year from procurement, all trusts expecting to deliver their bank and agency targets, planning for a pan NW London bank by the end of the year.



6. How we will deliver our plan:
Risks and actions to take in the short term

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	Development of a dashboard and trajectory, and regular monitoring of progress through joint governance Adoption of learning from vanguard and other areas	Access to learning from vanguards and other STPs
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	On-going quality surveillance to reduce risk	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	Support development of federations Early investment in primary care through joint commissioning Identification and support to vulnerable practices Digital solutions to reduce primary care workloads	Clarity about future of and funding for GMS and PMS core contracts
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 joint market management strategy On-going support to homes to address quality issues	
Can't get people to own their responsibilities for their own health	Self care and empowerment	Development of a 'People's Charter' Work with local government to engage residents in the conversation	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	Finance and estates	Submit a business case for capital in summer 2016 Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment.	Support for retention of land receipts for reinvestment, and potential devolution asks.
We are unable to access the capital required to increase capacity at the receiving hospitals quickly enough to address the sustainability issues at Ealing hospital	Finance and estates	Submit a business case for capital in summer 2016 that sets out the clinical and financial rationale to accelerate the timeline	Support for an accelerated timeline for the capital business cases
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	Development of workforce strategy, close working with HEENWL	

6. How we will deliver our plan:
Risks and actions to take in the short term

Risks	Category	Proposed mitigations	Support from NHSE
There is resistance to change from existing staff	People and workforce	OD support and training for front line staff Wide staff engagement in development of new models to secure buy in	
Providers are unable to deliver the level of CIPs required to balance their financial positions	Finance and sustainability	Establishment of new sector wide improvement approach to support the delivery of savings	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	Establishing a new political relationship and reflecting this in enhanced joint governance, taking a 'whole systems view' to investment and market management	
BI systems aren't in place to enable shifts of activity through integrated care	Information and technology	Work within new national standards on data sharing to support the delivery of integrated services and systems.	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
Lack of interoperability in our primary and community IT systems, EMIS and SystmOne, which prevents shared care records which support integrated care	Information and technology	Keep pressure up on supplier to deliver open interfaces.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	Work closely with partners to understand the 'Brexit' implications and provide staff with support to ensure they feel valued and secure.	Early clarity of impact Political messaging to staff

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	23-24	[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	25-26	[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	27-28	[1] Tulloch et al., 2008 [2] Royal College of Psychiatrists, 2012 [3] 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	29-31	[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	33-34	[1] ERIC Returns 2014/15 [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	35-36	[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	37-38	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

NHS Brent Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Ealing Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

NHS Harrow Clinical Commissioning Group

NHS Hillingdon Clinical Commissioning Group

NHS Hounslow Clinical Commissioning Group

NHS West London Clinical Commissioning Group

Brent

Harrow Council London

Hillingdon London

London Borough of Hounslow

The Royal Borough of Kensington and Chelsea

City of Westminster

West London Mental Health NHS Trust

Central and North West London NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

London North West Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Hounslow and Richmond Community Healthcare NHS Trust

The Royal Marsden NHS Foundation Trust

Royal Brompton & Harefield NHS Foundation Trust

London Ambulance Service NHS Trust

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust

NHS Health Education North West London

NHS England

NHS National Institute for Health Research

Clinical Research Network North West London

Imperial College Health Partners

wla West London Alliance

Report to:	Date of meeting
Trust board - public	**28 September 2016**

Improving the quality of care - CQC Update Report

Executive summary:

CQC registration for Q1 (2016/17)

- The Trust made 33 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.
- Three concerns about the Trust were raised with the CQC.
- The Trust was not inspected by the CQC in Q1.

CQC Re-inspection preparedness update: Outpatients and diagnostic imaging

- On 1 July 2016, the Trust received notice that the CQC will re-inspect the core service of Outpatients and diagnostic imaging at St Mary's, Charing Cross and Hammersmith hospitals on 22 and 24 November 2016.
- Inspection preparations to date include:
  - Establishing a CQC inspection assurance group
  - Establishing a task and finish group
  - Developing an inspection preparation project plan
  - Developing a communications plan
  - Developing a programme of quality reviews to include; unannounced core service reviews and walk rounds.
  - Submitting a 'Stage 1 and Stage 2 Provider Information Request' to the CQC

- Updates in relation to all inspection preparations will be reported as follows:
  - Fortnightly by the Task and Finish Group to the CQC Inspection Assurance Group
  - Monthly by the Task and Finish Group to the Outpatient Improvement Programme Steering Group
  - Monthly to the Executive Quality Committee, Quality Committee and Trust board in line with the current governance process

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(s) to the Board:

- 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	Janice Sigsworth, Director of Nursing	20 September 2016

CQC registration for Q1 and update

The following report provides an update in relation to the Trust's CQC registration. This report covers quarter 1 (Q1) of 2016/17.

1. Registration Status

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

2. Notifications made to the CQC

2.1. Mental health notifications

- In the best interests of patients and to support the safety and quality of care, the following applications were made to deprive patients of their liberties (DoLS applications):
  - 10 applications in April 2016.
  - 10 applications in May 2016.
  - 13 applications in June 2016.
- No patient deaths took place whilst being detained under the Mental Health Act.
- No certified treatment was sought or delivered (i.e. by a panel or second opinion appointed doctors (SOAD)).

3. Contact with the CQC (concerns and complaints)

- The CQC contacted the Trust about three concerns in Q1. The trust has responded to all three and have been dealt with to the CQC's satisfaction.
- No whistleblowing alerts were made to the CQC about the Trust in Q1.

4. CQC Inspections and Reviews

4.1. Inspections

- The Trust was not inspected by the CQC in Q1.
- The committee will remember that the Trust's sub-contractor for patient transport, DHL, was due to be inspected by the CQC in September 2016.The CQC have cancelled this inspection for internal reasons; it has not yet been rescheduled but will take place by March 2017.
- Through preparing for this inspection, an issue in relation to the applicability of DNACPR orders during a patient's transfer has arisen. Work is currently underway to understand this issue and to put actions in place ahead of the inspection.

4.2. CQC Reviews

4.2.1. National data security review

- The committee will recall that during Q3 of 2015/16, the Trust was selected to be involved in a national data security review being carried out by the CQC, with a visit taking place on 16 November 2015.
  - A report about the review has now been published by the CQC and can be found at: http://www.cqc.org.uk/content/safe-data-safe-care
  - Although the Trust is not identified by name, the Care Information Exchange has been used as an example of good practice in the report.

4.2.2. Review of how NHS trusts investigate and learn from deaths.

- All trusts were required to respond to a survey from the CQC in July 2016.
- The Medical Director's office provided the Trust's response
- The web page for the review can be accessed via the following link: http://www.cqc.org.uk/content/our-review-how-nhs-trusts-investigate-and-learn-deaths

5. Compliance with Legislation and Standards

5.1. NHS Accessible Information Standard

- The Trust had complied with the first phase of the new NHS Accessible Information Standard, and Phase 2 of the standard was required to be complied with by 31 July 2016.
- The Trust is not yet fully compliant with phase 2 of 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 patient paper medical records.
  - Staff can link with the Patient Experience team for support in any individual case where accessible information is needed but not available.

CQC Re-inspection preparedness update: Outpatients and diagnostic imaging

6. Background

- On 1 July 2016, the Trust received notice that the CQC will re-inspect the core service of Outpatients and diagnostic imaging at St Mary's, Charing Cross and Hammersmith hospitals on 22 and 24 November 2016.
- The purpose of the inspection is to check whether the Trust has done what it said it would do in the action plan submitted to the CQC following the previous inspection in September 2014, and whether the action taken has resulted in improved performance.
- The inspection will cover:
  - Main outpatient areas where people undergo as part of any speciality, physiological measurements, diagnostic testing, receive diagnostic test results, are given advice or receive care and treatment without being admitted as an inpatient or day case.
  - Diagnostic imaging services, such as diagnostic radiology tests.
- In line with how the service was inspected in September 2014, the current inspection is not expected to cover devolved outpatient areas or imaging procedures which are for treatment, such as interventional radiology.

7. Background

- Following the CQC's inspection of the Trust in September 2014, the CQC rated all three hospital sites as follows:

SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED		OVERALL
Good	The CQC does not rate for this core service	**Good**	**Inadequate**	**Inadequate**		**Inadequate**

8. Implications of the re-inspection for the Trust

- This is the first re-inspection of any service at the Trust since the CQC carried out the inspection in September 2014.
- The implications for the Trust depend on the outcomes of the inspection
- A positive outcome could lead to improved ratings:
  - For the core service

  - For one or all of the sites, particularly for the St. Mary's site due to how the ratings were assigned for the other core services.
- Due to the algorithm the CQC uses to aggregate ratings, an improved rating for a single core service is unlikely to change ratings for the Trust overall.
- It is important to recognise that the re-inspection will 'set the tone' for the CQC's inspection programme for the Trust during 2017/18 which will be based on the level of risk and improvements observed. That is to say, a good outcome could result in the trust not being on the CQC priority list for other inspections of cores services.

9. Inspection Preparations To Date

9.1. CQC Inspection Assurance Group

- A CQC assurance group has been established and compromises of the divisional triumvirate and colleagues from the nursing directorate.
- The group has been meeting weekly since 11th July to set out the approach for preparing for the inspection and to ensure there is senior oversight and assurance on progress against the key tasks that will need to be undertaken for the inspection as well as assurance about delivery of the actions identified from the previous inspection in 2014.
- A project plan for the inspection has been prepared.
- An evidence guide for each of the actions for outpatients from the previous CQC inspection has been developed to inform a line by line review underpinned by robust evidence.

9.2. Task and Finish Group

- On 13 July 2016, a kick off meeting was held with directorate managers to review the findings from the September 2014 inspection and set out the proposed approach to inspection preparations.
- A Task and Finish Group has been established Chaired by the Divisional Director of Nursing for Women's, Children's and Clinical Support.
- Representatives from diagnostic imaging also attend this group to ensure that the core service is being looked at in its entirety, not solely focusing on outpatients.
- The group will:
  - Monitor progress towards ensuring actions from the previous inspection are complete and underpinned by evidence
  - Provide operational support for preparing for the inspection, including the completion of actions identified on the project plan.
  - Follow up on any findings from quality reviews (e.g. core service reviews/walk rounds) that will take place as part of the inspection preparations.
  - Engage with staff on the 'shop floor' in the run up to the inspection
- The group's first formal meeting was held on 2nd August 2016 and it will meet fortnightly to begin with and weekly during the six weeks prior to the site visit.

9.3. Programme of quality reviews

9.3.1. Core service reviews

- Core service reviews of outpatients took place in July 2016 across all three sites. The review team felt that there were still some concerns relating to the same issues raised by the CQC in September 2014. However, it is important to note that strong improvements in leadership and the 'responsiveness' of some elements were observed.
- Feedback of the key findings was presented to the divisional triumvirate and the following actions have been undertaken in response across all three sites:

CQC Domain	Action Taken
SAFE	• Daily review checklist for OPD staff has been designed and being implemented to ensure clinic environment and equipment issues are resolved and that there is a consistent standard. • Medication sweeps have been carried out across sites and this has been included as part of the daily review checklist. • Fortnightly walk arounds by senior nurse implemented • Direct link and escalation process established between senior management team in OPD and estates and facilities to ensure timely resolution of issues.
WELL-LED	• Specific resource for OPD engagement agreed and currently going through recruitment process • Interviews held for an OPD matron role • General Manager and Senior Nurse for Outpatients reviewing roles and responsibilities of Senior Sister and Service Support Managers to ensure they meet the needs of the service. • Nurse staffing establishment review being undertaken by senior nursing team to include considering best practice from other organisations. • SOP developed for escalation of doctors turning up late to clinic and being trialled. • Divisional Director has started a programme of clinical engagement with clinicians
RESPONSIVE	• SOP has been developed to define the process for managing the forms in a timely manner. • An audit has been undertaken regarding clinic start times and doctors arrivals. Results to be shared shortly with divisions for action. • Outpatient appointment letters now outsourced through Xerox who are able to offer improved timeliness and tracking of letter production and postal service. Service currently available to approx. two thirds of all Cerner generated letters, with all letters due to benefit from this service by November 2016. • Analysis of short notice cancellations undertaken and process going forward to be discussed at next task and finish group. • Capacity and demand being reviewed by general and service managers to ensure wait times for appointments are reduced • Further actions being taken forward through the outpatient improvement steering group

9.3.2. Walk rounds

- A programme of outpatient walk rounds across the three hospital sites has commenced.
- The nursing back to the floor Fridays will also be utilised to support inspection preparation.
- A programme of estates walk rounds with an aim to make prompt improvements to the environment including ‘dump the junk’ sessions is underway.
- An ‘activity planner’ outlining the programme of quality reviews between July and November 2016 has been developed.

9.4. Communications and engagement

- A communications plan has been developed for the inspection (in conjunction with the communications team) and this has been launched.
- The divisional director for women’s children’s and clinical support has started a programme of clinical engagement with key stakeholders.
- It has been agreed that an additional dedicated resource for engagement (with staff, patients and other stakeholders) has been identified to support the inspection for the coming months.

- A staff information leaflet has been produced that outlines the five domains and what they mean to staff and will be distributed at the beginning of October

10. Provider Information Return (PIR) – Data requests from the CQC

- The CQC sent the Trust the 'stage 1 PIR' with the inspection notification letter in early July 2016.
- The stage 1 information is designed to support the CQC with their inspection planning.
- The Trust was asked to submit high level information relating to the type and location of the outpatient and diagnostic imaging clinics offered by the Trust (across the three sites) as well as staffing information in relation to these.
- The 'stage 2 PIR' was sent to the Trust at the end of August 2016 and was submitted to the CQC on by the deadline of 13th September 2016
- The stage 2 PIR is a more comprehensive data request about the core service, similar to what was requested during the inspection in September 2014.

11. Governance and reporting

- Updates in relation to all inspection preparations will be reported as follows:
    - Fortnightly by the Task and Finish Group to the CQC Inspection Assurance Group
    - Monthly by the Task and Finish Group to the Outpatient Improvement Programme Steering Group
    - Monthly to the Executive Transformation Committee, Quality Committee and Trust board in line with the current governance process.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**28 September 2016**

2015 National Cancer Patient Experience Report

Executive summary:

The results of the 2015 National Cancer Patient Experience Survey (NCPES) were published in July. The results represent a significant improvement on previous years and suggest that the approach taken by ICHT to improving the experience of patients with cancer, notably the IVHT/Macmillan partnership, has been successful.

This paper highlights key results and shows comparisons with other organisations and with previous years. The full report is available on the Quality Health website via the link below:

http://www.ncpes.co.uk/index.php/reports/local-reports/trusts/2823-ryj-imperial-college-healthcare-nhs-trust-2015-ncpes-report/file

Quality impact:

Delivering a high quality experience to patients with cancer is a key quality objective for the trust. It is a high priority given previous NCPES results.

Financial impact:

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

Risk impact:

ICHT's previous performance in the NCPES has had an impact on the reputation of the trust and resources. Support has gone into delivering a better experience of care for patients and families.

Recommendation(s) to the Committee:

The Board is asked to note the report and to endorse the trust's continuing approach to improving the experience of patients with cancer.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Guy Young	Janice Sigsworth	21 September 2016

1. Introduction

The 2015 National Cancer Patient Experience Survey (NCPES) was published on 05 July 2016. As the Board will be aware, ICHT has previously performed poorly in this survey.

Considerable work has been undertaken to improve the experience of patients with cancer since the 2013 results, most notably the partnership with Macmillan, and the latest results demonstrate the positive impact of that work. This is the best set of results in the NCPES that ICHT has returned to date.

Whilst there is clearly still a need to do more, there is a level of confidence that further improvements will be seen in the next survey.

This report summarises the results, which the Board is asked to note.

2. Background and methodology

This is the fifth NCPES, which focuses on the experience of cancer patients in acute hospitals.

The ICHT 2015 survey was based on a sample of 1248 eligible patients who were discharged from the trust during April, May and June 2015. 684 patients returned completed questionnaires giving a response rate of 55%. This is below the national average (66%) but better than previous years.

The 2015 survey itself and its reporting underwent a number of changes. It was shortened to 50 questions, some of which were amended. The reporting this year also looks different and in line with other national surveys it now presents results using an 'expected range'. This means that trusts are flagged as an outlier only if there is statistical evidence that scores deviate (positively or negatively) from the range of scores that would be expected for trusts of the same size. The results used for the expected range are also case mix adjusted, meaning that factors such as age, gender, ethnic background and tumour type are factored into the scores.

3. 2015 results

As with other national surveys, the best indicator of the performance of the trust is how often question scores fall within the expected range. Out of the 50 questions in the survey ICHT:

- Scored above the expected range in 1 question
- Scored within the expected range in 37 questions
- Scored below the expected range in 12 questions

The question where the trust scored above the expected range was related to whether taking part in cancer research was discussed with the patient.

The questions where the trust scored below the expected range covered the following issues:

- Given complete explanation of tests in an understandable way
- Felt that the treatment options were completely explained
- Told about side effects that could affect them in the future
- Ease of contact with CNS
- Understandable answers from CNS to important questions
- Doctors & nurses not talking in front of patient as if they were not there

- Given clear post discharge written information
- Doctor had the right notes with them
- Patient has all the information they needed about radiotherapy
- Given enough care form health or social care services during treatment
- Hospital & community staff always worked well together
- Overall the administration of care was good or very good

It should be noted that the deviation from the lower limit of the expected range was very small and in most cases a 1% or 2% shift would have moved the trust into the expected range. For example the ease of contacting the patient's CNS scored 82%, which was the lower limit of the range; this was frustrating because the ICHT score for that particular question had improved by 23% since the last survey.

4. Compared with other trusts

A comparison of the 2015 results between similar London trusts is also encouraging as shown below. The majority of scores for the 50 questions for ICHT are in the expected range as opposed to previous years where the majority were in the bottom 20%. The table below shows how ICHT compares to similar trusts in London

The average rating of care, shown on the bottom row, is based on a single question scored out of 10. The average rating of care is fairly consistent across London.

	GSTT	C&W	ICHT	King's	UCLH	Barts	NMH
Lower than expected	3	3	12	14	18	25	30
As expected	42	47	37	36	30	24	20
Higher than expected	5	0	1	0	2	1	0
Net score (higher – lower)	2	-3	-11	-14	-16	-24	-30
Average rating of care	8.7	8.6	8.6	8.5	8.6	8.4	8.3

5. Compared to previous years.

Because of the changes to the survey, not all questions can be compared with previous years and, where questions are the same, comparison should be made with a degree of caution. However, by using non-case mix adjusted scores a reasonable comparison can be made with what patients said in 2014. Ten questions (shown below) improved by 5% or more:

- Patient found it easy to contact their CNS (up 23%)
- All staff asked patient what name they preferred to be called by (up 19%)
- Patient's family or someone close to them definitely had opportunity to talk to doctor (up 12%)
- Patient definitely involved in decisions about care and treatment (up 10%)
- Patient had trust and confidence in all ward nurses (up 7%)
- Hospital staff told patient they could get free prescriptions (up 6%)
- Always/nearly enough nurses on duty (up 6%)
- Patient thought they were seen as soon as necessary (up 5%)
- Patient told they could bring a family member or friend when first told they had cancer (up 5%)
- Patient given the name of the CNS who would support them through treatment (up 5%)

The majority of these improvements can be directly tracked to work that has been done over

the last 24 months, such as the navigator service, the reorganisation of the CNS function and the SMILE campaign.

Three questions worsened by more than 5%:

- Patient was able to discuss worries or fears with staff (down 6%)
- (GP) Practice staff definitely did everything they could to support patient (down 7%)
- Taking part in cancer research was discussed with the patient (down 16%)

Interestingly, despite the significant drop, the research question still scored above the expected range and the other two within the expected range.

6. Summary

The results of the 2015 NCPES show a positive step forward. This is a validation of the work that the trust has been undertaking for the last two years, particularly through the partnership with Macmillan. The strengthening of the CNS function across tumour groups and the development of the navigator service have been integral to this improvement, but local developments around the functioning of the MDTs, the 100 day events and the SMILE campaign have also clearly had an impact.

It should be noted that the patient sample for this survey was from a year ago, at a time when not all tumour groups were benefiting from the navigator service and not all the new nurse specialists were in post. There is every reason to suspect therefore, that the 2016 NCPES, which is planned for this autumn will show further improvement.

As a result of the improvements seen, the on-going plan is, in essence, more of the same. The corporate cancer team feel that the current approach is the right one and the focus should be on continuing to embed the changes already underway. This year will also see the start of phase two of the Macmillan/ICHT which will focus on living with and beyond cancer.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 September 2016

Bi-annual update from ICHT's Emergency Planning, Resilience and Response (EPRR) team

Executive summary:

The purpose of this report is provide assurance in relation to the Trust's Emergency Planning, Resilience and Response (EPRR) arrangements and plans.

The paper outlines the way in which the Trust engages in the NHS England, London EPRR assurance framework, noting that the Trust is currently rated as having substantial compliance, and that plans are in place to move to full compliance. It also details the Trust's approach to the development and testing of business continuity plans, and outlines the remaining 2016/17 key actions.

Quality impact:

In addition to our statutory requirement through the Civil Contingencies Act, EPRR forms part of the patient safety and quality agenda of Care Quality Commission regulation.

Financial impact:

Has no direct financial impact.

Risk impact:

The paper seeks to assure the Trust's executive and board that risks associated with EPRR are being mitigated and managed appropriately. EPRR risks are raised through the Trust's internal risk process.

Recommendation(s) to the Committee:

The Committee is asked to:

- note the report
- confirm that it provides sufficient assurance in relation to EPRR

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

Author	Responsible executive director
Merlyn Marsden, Site Director Charing Cross & Hammersmith Hospital	Janice Sigsworth, (Accountable Executive Officer in relation to Emergency Planning)

EPRR Bi-Annual Update – 2016

1. Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

The Civil Contingencies Act (2004) requires NHS acute providers to demonstrate that they can respond to incidents whilst maintaining appropriate patients services.

The current threat level for international terrorism in the UK is SEVERE. The recent terrorist related incidents around the world are underlining our continued emphasis on work in relation to Major Incident, Trauma, Mass casualties and ensuring staff are aware of their role should a major incident occur.

Particularly highlights in the first half of 2016 have been:

- Participation in the pan-European Exercise Unified Response (March) - a large scale and complex, live and command post exercise. The Trust exercised its Major Incident, Mass Casualty and Major Trauma incident plans alongside communication plans and command rooms live simulation, demonstrating to NHS England, our staff and stakeholders that they can take assurance from and be confident in our ability to respond to a large scale mass casualty incident in London. Learning from this exercise is being reflected in changes to the Trust's plans, Major Trauma Network and Major Incident plans.
- The exercising of our business continuity response to an internal ICT failure, successfully achieved all of the exercise objectives .Lessons learnt are being incorporated into existing plans through a newly formed core group who will oversee the business continuity planning.

2. NHS England, London EPRR assurance update

As part of the assurance arrangements, NHS England has developed a framework of indicators that each trust uses to measure the level of confidence and ability of the organisation to respond.

The assurance process centres around eight core standards for EPRR (containing 51 detailed evidential measures), and a further four core standards relating to (HAZMAT) Hazardous Materials/ (CBRN) Chemical, Biological, Radiological and Nuclear EPRR response core standards (containing 31 evidential measures).

General EPRR core standards cover: Governance; Duty to assess risk; Duty to maintain plans – emergency plans and business continuity plans; Command and control; Duty to communicate with the public; Information sharing; Co-operation; and Training and exercising. (HAZMAT) Hazardous Materials/ (CBRN) Chemical, Biological, Radiological and Nuclear EPRR response core standards cover: Preparedness; Decontamination; Equipment; and Training. As part of the process, a one-off 'deep dive' reviewing flu planning was specifically included in 2015/16 which contained a further four detailed evidential measures.

A total of 85 compliance questions were peer reviewed and validated by NHS England, London. The Trust achieved a total of 85% GREEN (full or substantial compliance) and 15% AMBER (partial) against EPRR standards, and 100% GREEN for CBRN and HAZMAT standards. ICHT received no RED, non-compliant ratings. Overall, the Trust's rating is substantial, and an action plan has developed to deliver the 15% of AMBER ratings to enable to the Trust to achieve full compliance. Delivery of the key objectives and completion of the assurance action plan will be overseen by the Trust's EPRR committee which is chaired by the medical director.

3. Business Continuity progress report

The 'deep dive' of the 2016/17 NHS England EPRR assurance is business continuity planning. The Trust has well-rehearsed Business Continuity arrangements from power failure to ICT downtime, and the wards and staff are aware of the plans and actions to be taken to provide patient care during incidents where business as usual is interrupted.

The Business Continuity planning cycle (overseen by the EPRR committee) consists of:

- Development of a Business Continuity Strategy (in place and reviewed annually)
- Undertaking a Business Impact Analysis (BIA) (all areas have submitted, an subject to regular review)
- Engagement of teams in producing the Business Continuity Plan (BCP) (service specific plans next due for review at October's EPRR Forum)
- Completing exercises to test the plans (for example, an Autumn evacuation exercise is planned incorporating BCPs and fire evacuation plans).

4. Key remaining 2016/17 actions

- EPRR self-assessment submitted and waiting outcome.
- Complete all directorate and divisional business continuity plans (planned completion 30 November 2016)
- Ensure completion of Silver and Gold 'Strategic Leadership in a Crisis' training programme delivered to all on-call staff (by December 2016)
- Approve Business Continuity Strategy and BCP's at October EPRR Forum
- Plan and deliver autumn evacuation exercise
- Ensure completion of NHS England funded replacement and training of new decontamination suits for use during a chemical or bio-hazard incident

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board - public	**28 September 2016**

St Mary's Phase 1 redevelopment – engagement and consultation

Executive summary:

As reported at the July public trust board, we are progressing an opportunity to bring forward a phase 1 redevelopment of the St Mary's Hospital site. This will see the creation of a brand new building on the eastern side of the estate – at the location of Salton House, the Dumbell, and Victoria and Albert buildings. This will enable us to bring together the majority of our outpatients services (currently provided from 40 different locations) with supporting diagnostics in a modern, flexible and welcoming facility.

Engagement

In line with the Trust's commitment to involve staff, patients, carers, GPs, local residents, community groups and other stakeholders in the phase one redevelopment, we began a wider programme of engagement with all our audiences in July.

A key element of our engagement programme has been the public exhibition held on 8-10 September at St John's Church in Hyde Park Crescent W2. The exhibition display materials are included as an appendix.

Invitation letters for the public exhibition were posted out to around 8,000 local residents covering a distribution area agreed with Westminster City Council.

We sent additional letters to some 400 close neighbours to St Mary's Hospital, several of whom we are in direct contact with, meeting them in advance of the exhibition and with further meetings planned.

As well as promoting our engagement activities through our regular electronic newsletters with stakeholders, GPs and 'members', all these groups received further exhibition invitation letters via email – totalling nearly 4,000 messages.

Key stakeholders – including all Westminster City councillors, north west London council leaders and health cabinet members, London Assembly members, MPs, CCG chairs and managing directors, and local community and neighbourhood groups - were also contacted with letters via email. Many took up earlier offers of direct briefings and a tour of our site – this is in addition to the ongoing close communications between the project team and advisors and key decision makers and influencers.

Our Trust social media channels – Twitter and Facebook - carried several promotional messages before, during and after the exhibition. News stories were published about the exhibition and our proposals on our Trust website and in local media.

On Thursday 8 September, to coincide with the first day of the exhibition, we launched a new

dedicated website section: www.imperial.nhs.uk/stmarysphase1 to provide information on the proposals and an on-line survey for feedback.

The Evening Standard published an article about the proposed phase one redevelopment on Friday 9 September.

Exhibition visitors were able to view the display of the proposals on a set of ten boards and meet our redevelopment project team as well as Trust clinicians and managers. A 'prezi' animation of the improvements for patients was also shown continuously on a TV monitor. The number of visitors to the exhibition was:

- Thursday 8 September (2-8pm): 89
- Friday 9 September (2-8pm): 81
- Saturday 10 September (10am-4pm): 76
- Total visitors: 239

A questionnaire feedback form (see appendix) was provided and visitors were encouraged to complete and return these during their visit:

- Feedback forms received so far: 96

We have had just under 400 unique views of the dedicated website section so far.

Next steps

We have begun the process of reviewing and analysing all the feedback in order to provide input to the development of our planning application, to be submitted to Westminster Council as soon as possible, and assess any further actions for the consultation process.

The main themes that can be identified at this stage are:

- Positive support for improvements for patients and aims of the phase one redevelopment: better care, improved patient experience and replacement of ageing buildings.
- General support for the design of the new building and the outpatients services it accommodates.
- General support for Trust proposal for a new road incorporating an extended Winsland Street (subject to a separate planning application).
- Specific concerns raised by close affected neighbours who are residents of Westcliffe Apartments regarding height of proposed building and traffic issues.

The communication channels for feedback on our proposals will remain open and specific meetings with key residents and community groups are in the process of being organised for the September/October period. We are also working up plans for involving more staff, patients, local people, GPs and other stakeholders in the detailed design and new ways of working for the outpatients building and service.

We are also preparing a strategic outline case which will set out the case to support the development of the new outpatients facility. This business case will be presented to trust board for approval at the next meeting.

Quality impact:

Meaningful engagement and involvement are key to the success of the proposals

Financial impact:

The costs are within the allocation set within the phase 1 budget.

Risk impact:

Key risk mitigations include:

- Particularly close engagement with residents of the Westcliffe Apartments.
- Continued, proactive engagement about our proposals with all our key stakeholders and a prompt response to questions and comments

Recommendations to the Committee:

For noting/feedback

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Mick Fisher, Head of public affairs	Michelle Dixon Director of communications	22 September 2016

Imperial College Healthcare NHS Trust

Welcome

Imperial College Healthcare NHS Trust is currently consulting on proposals to redevelop the eastern part of St Mary's Hospital.

The hospital is an important part of the local community and so we really want your feedback on our plans.

The starting point for everything is our patients. This redevelopment will create a brand new building to help us provide you with the very best care, both now and in the future. It is also a major step towards our goal of a full redevelopment of our site.

Please see the *Your comments* section at the end of this display for how to give us your feedback.

Dr Tracey Batten
Chief executive

www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

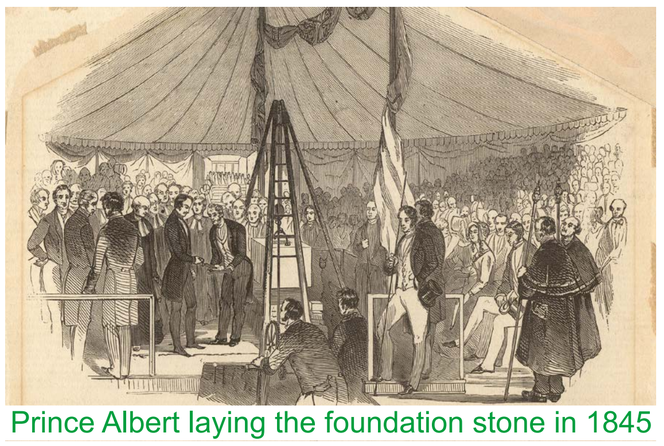
Responding to changing needs

St Mary's Hospital is the major acute hospital for north west London. It has a proud history of great care and innovation. Today, we provide a wide range of healthcare services for around 500,000 adults and children each year, including a 24/7 accident and emergency department and consultant and midwife-led maternity units.

As part of Imperial College Healthcare NHS Trust and in partnership with Imperial College London, we are also an academic health science centre, supporting rapid translation of research and excellence in education.

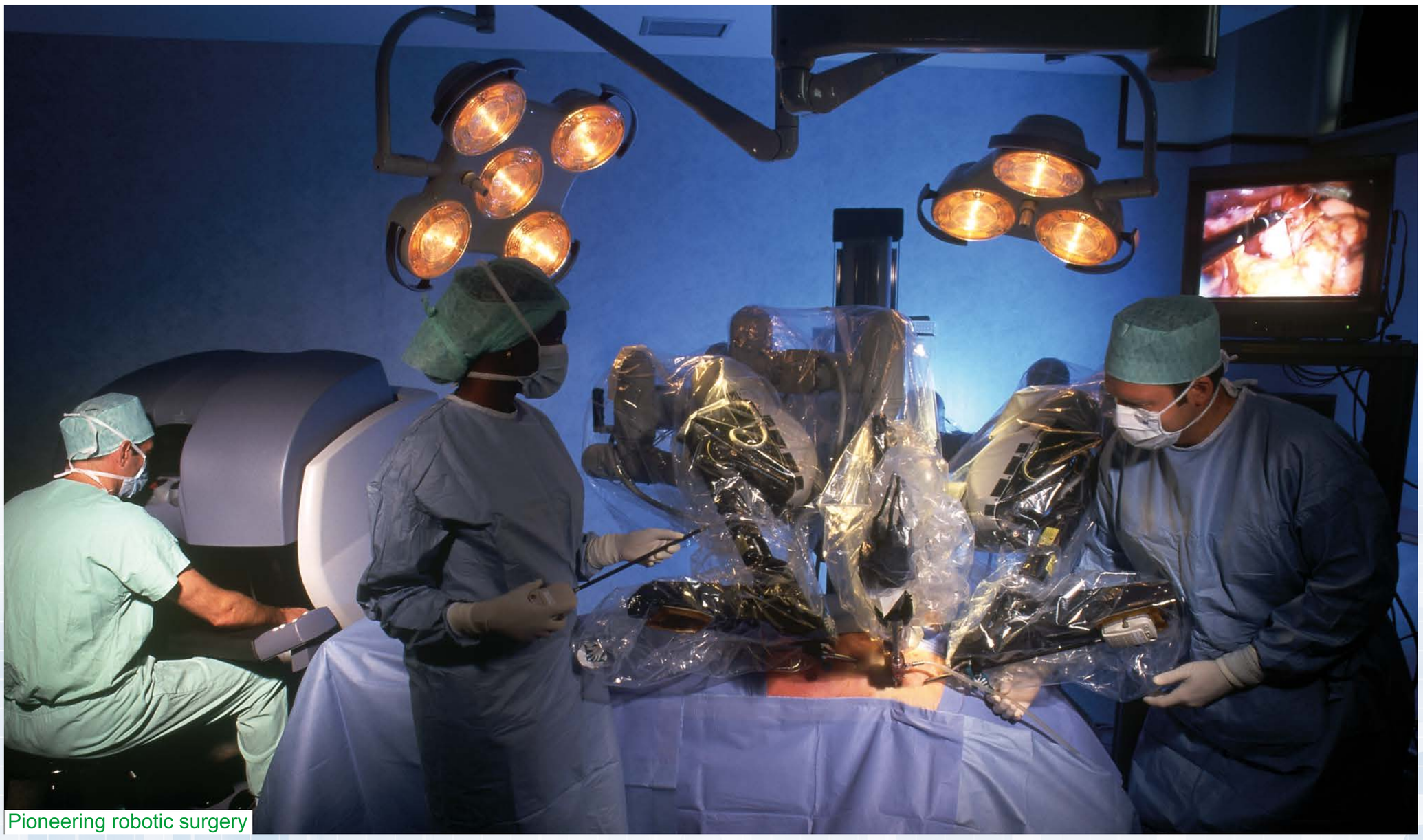
The hospital's estate has grown and evolved since it was opened in 1845, meeting vastly changing needs over the decades. Milestones include the discovery of penicillin in 1928, the creation of the NHS in 1948, pioneering robotic surgery in 2001 and, in more recent times, the development of our major trauma centre.

The hospital must continue to respond to changing needs. We want our patients and staff to be able to take advantage of new technologies and practices to make care as safe and effective as possible, as well as ensuring the best possible experience for everyone visiting and using our facilities.


Prince Albert laying the foundation stone in 1845

Fleming and the discovery of penicillin


Maternity unit


Pioneering robotic surgery

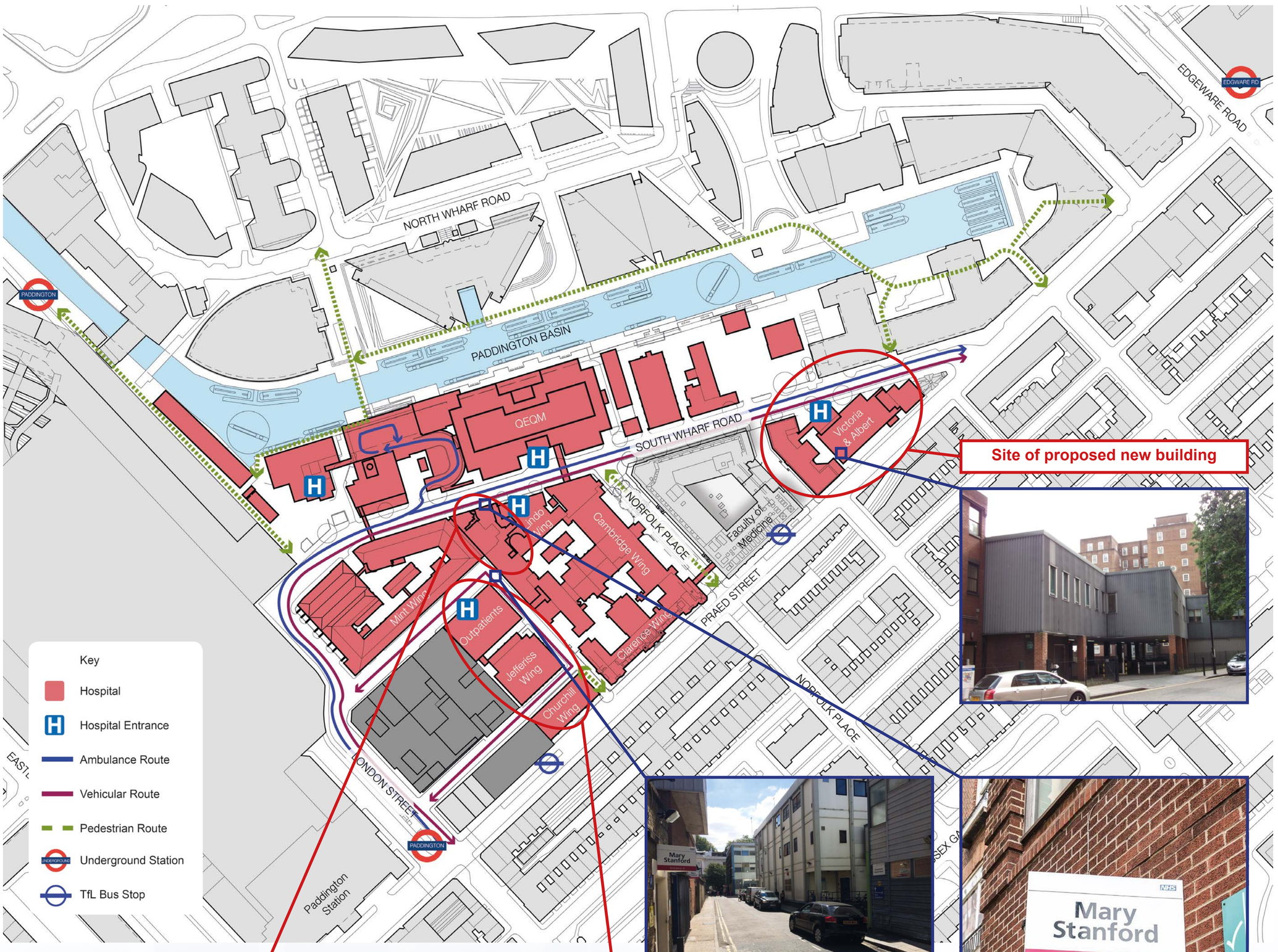
www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

Our proposal

We are proposing a brand new, eight-storey building on the current location of Salton House, the Dumbell and the Victoria and Albert buildings.

This will allow us to bring together the majority of St Mary's outpatients services, with supporting diagnostics, currently provided from 40 different locations. This will include all services provided in the Jefferiss Wing, Winston Churchill building, the main outpatients department and part of the Mary Stanford building.



www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

Why a new building is so important

Our proposal is driven by three main needs:

- **To support better care** – healthcare and other advances are allowing us to live longer, often with a number of long-term health conditions. It is really important to provide integrated care, tailoring and combining different specialist services to meet each individual's needs. We also want to do more to help our patients to recover quickly and to stay well.
- **To improve patient experience** – we want to provide our services in ways that will make it as easy and as stress free as possible for our patients, their carers and families, as well as ensuring our staff are able to work safely and effectively too.
- **To replace ageing buildings** – a third of the buildings on the St Mary's site are over a hundred years old and are expensive to maintain and to run. Our new building will be more efficient, using the best practice in design and technology, to enhance patient and staff experience.

Our proposed new building responds to these needs, and will deliver five key benefits for patients:

Everything in one place

- The majority of outpatient services in one building along with related diagnostic services including blood tests.

Faster, more holistic care

- Co-ordinated, same day appointments for patients with multiple health needs.
- Diagnostic tests, results and consultation all in one day, where possible.

Improved access

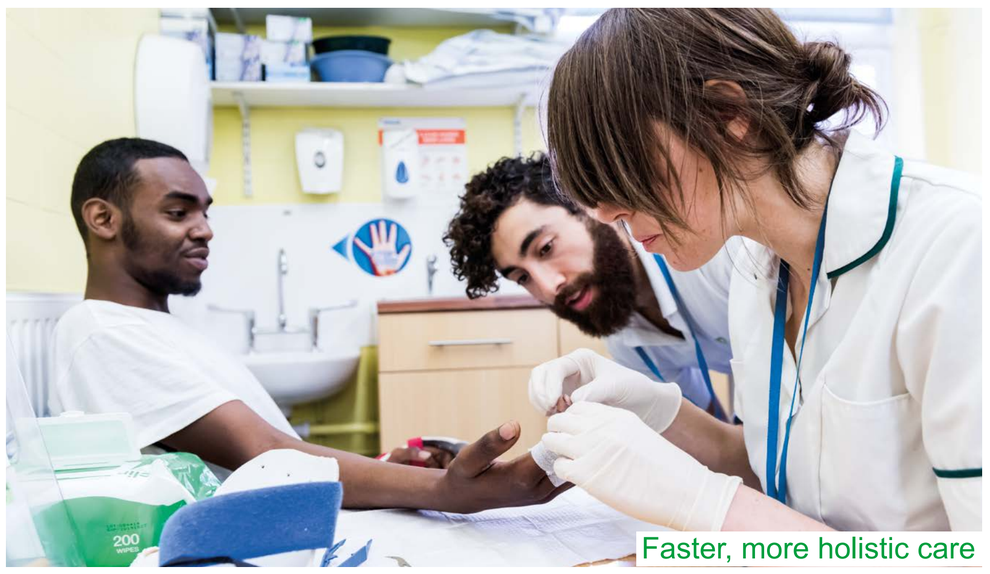
- Evening and weekend clinics.
- Follow-up consultations via telephone or Skype, where appropriate.
- Technology to enable more efficient and flexible appointment scheduling.

Better visitor experience

- Real-time service information throughout the building.
- Text message alerts with clinic and patient updates.
- Fast check-in, café, children's play area and easy-to-follow signage.

Health improvement

- Space for community health and wellbeing sessions, research and training.


Faster, more holistic care

Better visitor experience

www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

Proposed design

Artist’s impression – From Praed Street looking west

www.imperial.nhs.uk/stmarysphase1

Proposed design

Artist’s impression – On Praed Street looking towards Paddington Station

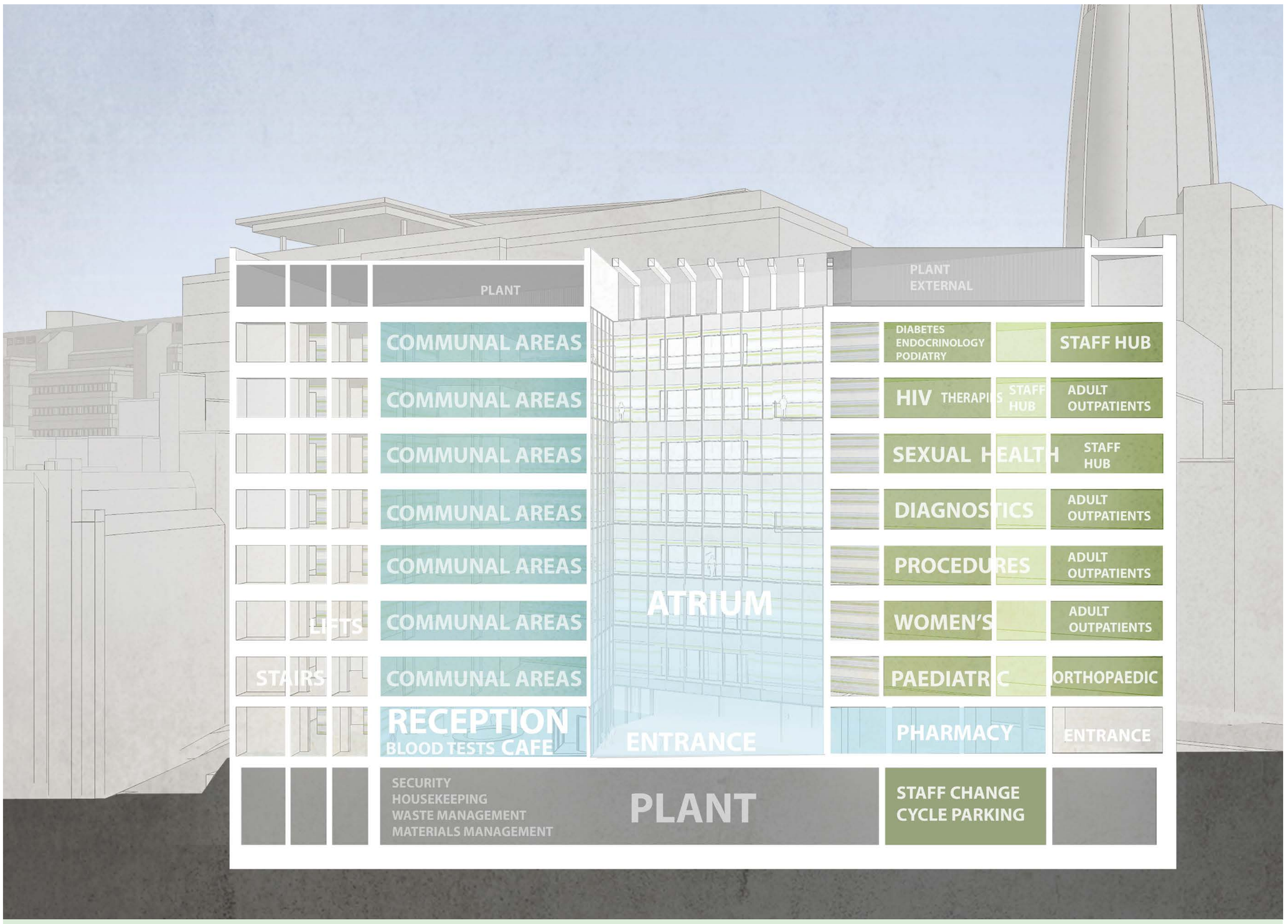
Artist’s impression – New entrance on Praed Street

www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

Proposed design

Cross section



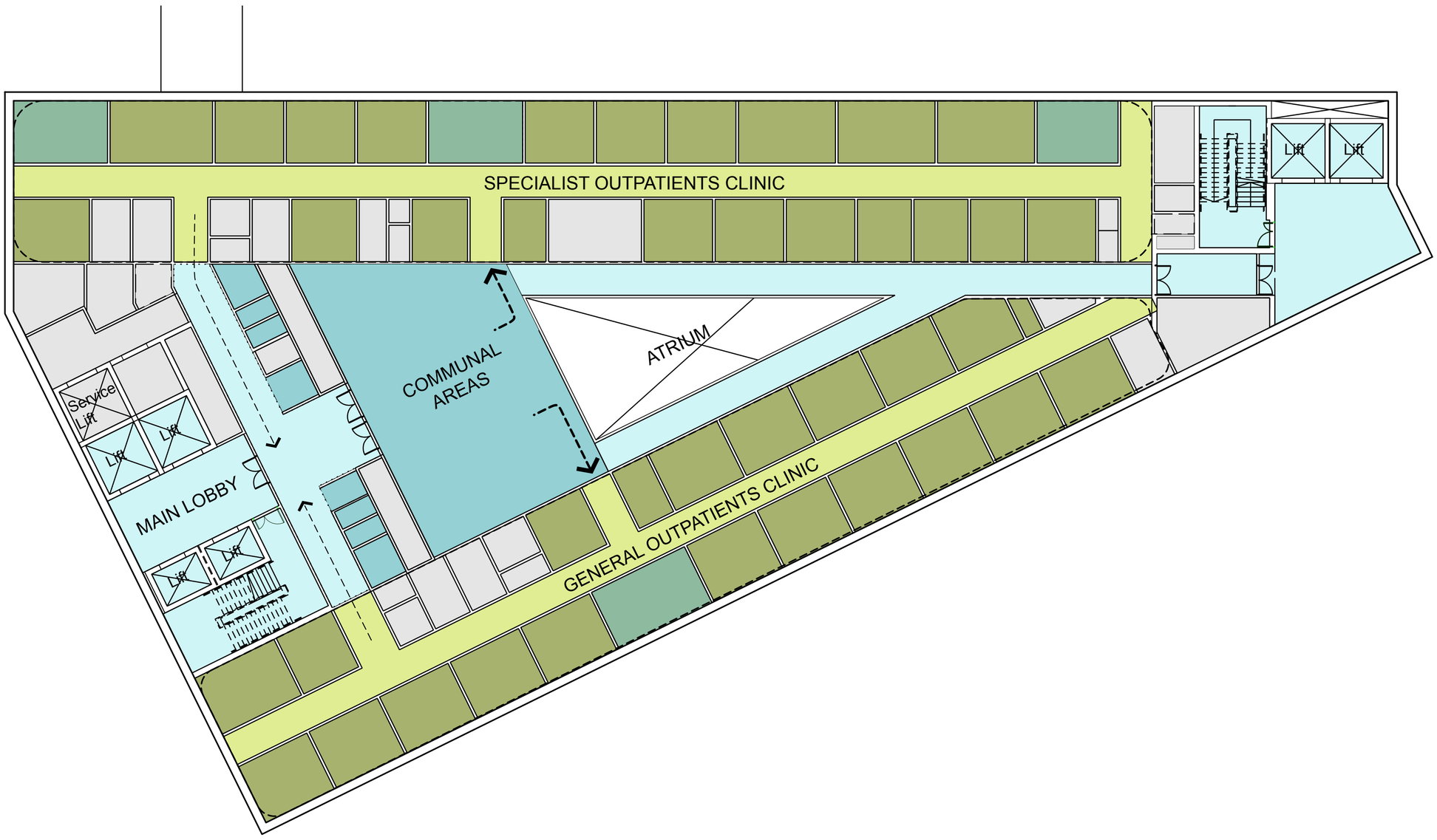
Overview

- Eight storeys.
- Open and inviting walk-in entrances from Praed Street and South Wharf Road.
- Public courtyard linking both streets.
- Atrium at the centre of the building, drawing in light to create a welcoming environment.
- Pick up / drop off spaces on South Wharf Road, including hospital transport for patients.
- Reception next to café and blood tests, for convenience.
- Ground floor pharmacy.
- Flexible design, allowing space for specific clinics to be increased or decreased in response to need and enabling multiple uses where possible, including for research, teaching and health and wellbeing sessions.

Imperial College Healthcare NHS
NHS Trust

Proposed layouts

Typical upper floor

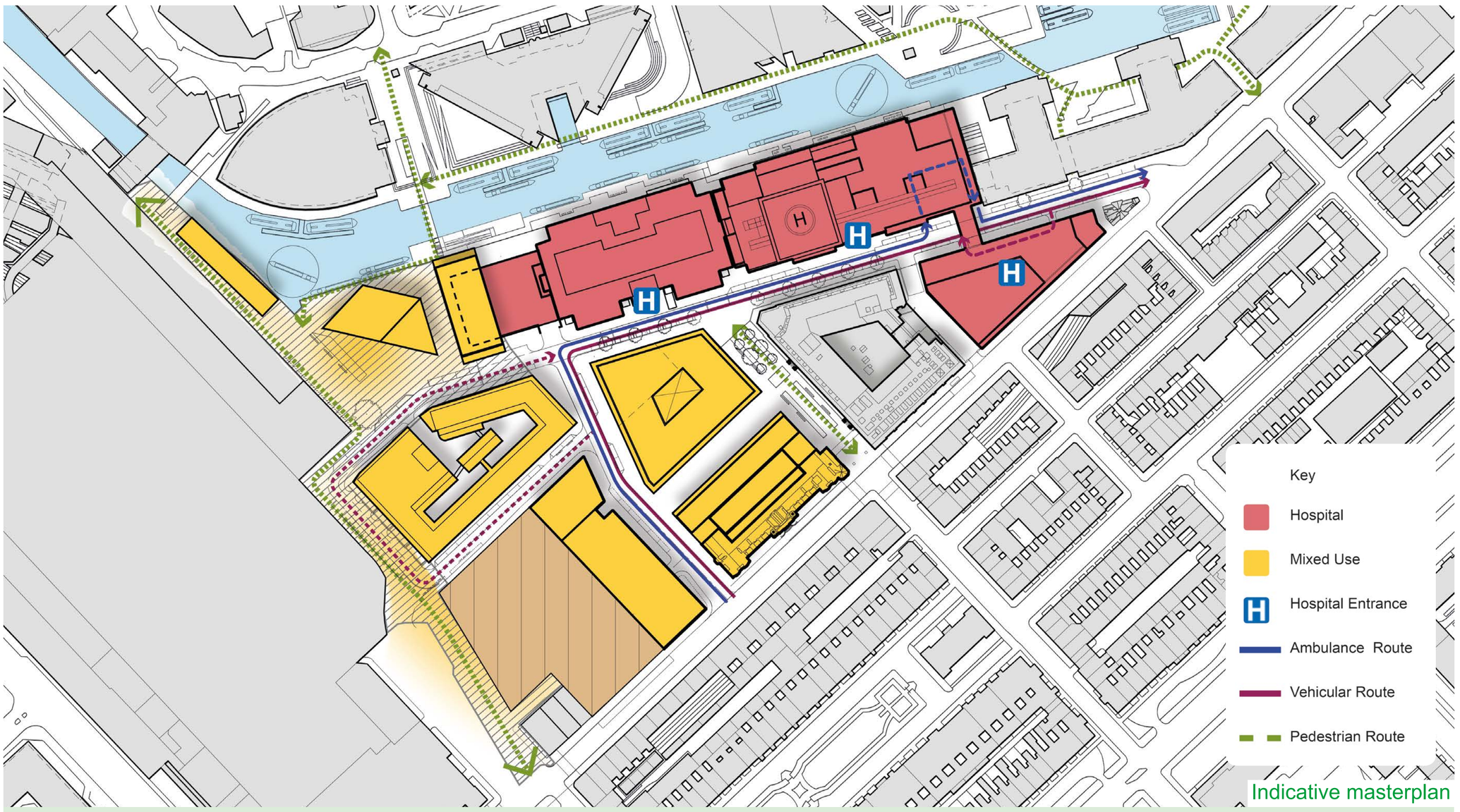


Ground floor

www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

Indicative whole-site redevelopment



Indicative masterplan

The proposed new building is planned as the first phase of a full redevelopment of the St Mary's site:

- At this stage, our 'masterplan' is indicative only of the redevelopment that we would propose. It would be subject to separate consultations and planning applications.
- Linking in with, and supporting the wider regeneration of the Paddington area, we want to develop other new and refurbished buildings as part of St Mary's Hospital and for the land surplus to our requirements to be used for a mixture of purposes.
- The capacity of our new and refurbished healthcare facilities will be as large as that provided by our current facilities, and will include provision for the Western Eye Hospital which is due to be relocated on the St Mary's site in a future phase of development.
- We are proposing that the phase 1 building will be connected to the later phase hospital development by a bridge across South Wharf Road.
- We are proposing that there is a new road, incorporating an extended Winsland Street, to improve access to the hospital, especially for emergency and other patient transport. This will be subject to a separate planning application.
- We are proposing a helicopter pad as part of the later phase development to bring access to our major trauma unit into line with other units in London.

www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS
NHS Trust

Thank you

We very much appreciate the time you have taken to visit our exhibition to find out about our proposal. We hope that you will be happy to provide your feedback.

Your comments

You can share your views with us by:

- Filling in a response form today, or returning it to us by freepost [see address below]
- Writing to FREEPOST RRAJ-KGLE-AYTR, Imperial NHS consultation, 5th Floor, 198 High Holborn, London WC1V 7BD
- Emailing trust.communications@imperial.nhs.uk
- Calling the communications team on 0203 312 7674
- Visiting our website www.imperial.nhs.uk/stmarysphase1

What happens next?

We hope to submit a planning application to Westminster City Council in October 2016. Before this, we will carefully review and incorporate the feedback from our staff, patients, community and partners. Our estimated project timings are:

- Initial engagement and consultation with community, patients and staff, July to October 2016
- Planning application, October 2016
- Planning decision, spring 2017
- Building begins after site clearance, late 2018
- Building complete, late 2020

Engagement will continue as we progress with further detailed design of the building and ways of working during this time.

We want to keep you informed and to provide opportunities for you to continue to shape our plans over the coming months. Please make sure you give us permission to keep in contact.

Supported by Imperial College Healthcare Charity

www.imperial.nhs.uk/stmarysphase1

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board- public	28 September 2016

NHS Improvement Single Oversight Framework

Executive summary:

The Single Overview Framework (SOF) replaces the Trust Development Agency (DA) Accountability Framework by which individual trust's performance had previously been assessed. It aims to provide an integrated approach for NHS Improvement (NHSI) to oversee both NHS trusts and foundation trusts, and identify the support they need to deliver high quality, sustainable healthcare services. Its stated aim is to help providers attain and maintain CQC ratings of 'good' or 'outstanding'.

The SOF does not change the statutory responsibilities of either the NHS Trust Development Authority or Monitor, under the auspices of NHSI.

The Framework has been considered by the executive committee, and arrangements are in hand to ensure our KPI scorecard and other monitoring processes align fully with the new requirements.

Quality impact:

The SOF has been designed to align with, and support improvement in, all CQC domains.

Financial impact:

There is no direct financial impact of the SOF itself.

Risk impact:

The Trust has long been subject to a range of oversight frameworks; the particular risks associated with this manifestation will become clearer over the next few months. This will be addressed and managed or mitigated

Recommendation(s) to the Trust board:

The Trust board is asked to note the paper, and further note that measures are being put in place to provide the Trust board with assurance of Trust compliance with the SOF.

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 company secretary	Dr Tracey Batten Chief executive	21 September 2016

NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK

Overview of the framework

The Single Overview Framework (SOF) aims to provide an integrated approach for NHS Improvement (NHSI) to oversee both NHS trusts foundation trusts, and identify the support they need to deliver high quality, sustainable healthcare services. Its stated aim is to help providers attain and maintain CQC ratings of 'good' or 'outstanding'.

The SOF does not change the statutory responsibilities of either the NHS Trust Development Authority or Monitor, under the auspices of NHSI.

Oversight themes

in carrying out its role NHSI will oversee and assess providers' performance against five themes:

Theme		Overview of oversight measures
1	Quality of Care	NHSI will use CC's most recent assessments of whether a provider's care is safe, effective, caring and responsive. In-year information where available Delivery of the four priority standards for 7-day hospital services
2	Finances and use of resources	Focus on a provider's financial efficiency and progress in meeting its control total Use of resources approach is being co-developed with CQC
3	Operational performance	NHS constitutional standards Other national standards
4	Strategic change	How well providers are delivering the strategic changes set out in the Five year Forward View with a particular focus on STPs and new care models
5	Leadership & improvement capability (well-led)	Building on their well-led framework, CQC and NHSI will develop a shared system view of what good governance and leadership looks like, including the ability to learn and improve.

While the five themes link to CQC key questions, they are not identical. Work continues between the two bodies to move towards a single combined assessment of quality and use of resources. Work also continues between NHSI, CQC and NHS England to produce a single set of metrics and approach to reporting, as recommended in the Carter review; such metrics will be included in the Model Hospital.

NHSI are using the NHS provider licence (statutorily applicable only to foundation trusts, although the TDA have powers to give similar directions to NHS trusts) as the basis of their oversight (intervention) of (in) trusts.

Summary of information

In 2016/17, existing oversight templates will be used; notice will be given prior to a change of collection being introduced.

	In-year	Annual / less frequently	Ad hoc
Quality of Care	In-year information to identify any areas for improvement	Annual Quality information	Results of CC inspections CQC warning notices, fines, civil or criminal actions etc
Finances and use of resources	Monthly returns	Annual plans	One-off financial events (eg sudden drop in

			income) Transactions / mergers
Operational performance	Monthly/ quarterly (in some cases weekly) operational performance information		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of STP Progress of any new care models etc	STPs	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership & improvement capability (well-led)	3rd information with governance implications Organisational health indicators (staff absenteeism / staff churn / board vacancies)	Staff and patient surveys 3rd party information with governance implications (quality surveillance' medical colleges' auditors; H&S etc)	Findings of well-led reviews 3rd party information with governance implications (quality surveillance' medical colleges' auditors; H&S etc)

The information team is currently reviewing the full list of proposed metrics to ensure there are no gaps in existing Trust data collection.

Segmentation and level of support

Depending on the extend of support identified by NHSI as being required (through its oversight process and performance against the above measures), NHSI will segment providers into four:

Segment	Description	Level of support	Review frequency
1 – maximum autonomy	No potential support needs identified across the five themes – lowest level of oversight and expectation that providers in segment 1 will support	Universal support	Subject to quarterly review, unless there is evidence that a provider is in breach of its licence, or equivalent for NHS trusts
2 – targeted support	Potential support needed in one or more of the five themes, nit not in breach of licence or equivalent	Universal support Targeted support as agreed by provider: • To address issues • help provider move to segment 1	On-going- where annual or ad-hoc monitoring flags a potential support need, NHSI will review the provider's situation and consider whether it needs to change it allocated segment.
3 – mandated support for significant concerns	The provider is in actual/suspected breach of the licence or equivalent with very serious/complex issues that may mean that they are in special measures	Universal support Targeted support Mandated support as determined by NHSI: • To address specific issues and help provider move to segment 2 or 1 Compliance required	On-going- as above
4 – special measures	The provider is in actual/ suspected breach of its licence or equivalent with very serious/ complex issues that may mean that they are in special measures	Universal support Targeted support Mandated support as determined by NHSI: • To help minimise the time the provider is in segment 4 Compliance required	On-going- as above

Support activities

Segment	Level of support
1	Universal support, including tools, guidance, benchmarking information Made available for providers to access
2	Universal support Targeted support as agreed with the provider: • To address issues and help move the provider to segment 1 • Either offered to provider (and accepted voluntarily) or requested by provider
3	Universal support Targeted support Mandated support as determined by NHSI • To address issues and help move the provider to segment 1 or 2 • Compliance by trusts is required
	Universal support Targeted support Mandated support as determined by NHSI • To help minimise the time the provider is in segment 4 • Compliance by trusts is required

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	28 September 2016

Annual Workforce Equality Report 2015-16

Executive summary:

This report provides an overview of key workforce equality metrics for the year 2015-16. The annual workforce equality report, appended to this report, incorporates the information required by the Workforce Race Equality Standard and will be posted on the trust website in order to meet our statutory duty under the Equality Act. The information within the report is used to monitor progress and to inform future actions to promote equality and combat discrimination.

This report is for noting.

Quality impact:

Aligns to the CQC well-led domain.

From April 2016, progress on the Workforce Race Equality Standard is being considered as part of the 'well led' key question for CQC's inspections.

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Committee:

The committee 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.

Author	Responsible executive director	Date submitted
Martyna Ciastek, Pay and Reward Manager	David Wells, Director of P&OD	21 September 2016

Annual Workforce Equality Report 2015-16

Purpose of report:
The report is for noting.

Introduction:
The annual workforce equality report provides a overview of key workforce equality metrics for the year 2014-15. In addition, it provides information required by the Workforce Race Equality Standard. The report identifies a number of current and future initiatives aimed at promoting workforce equality.

- **Workforce Composition**
  Ethnicity - the trust's workforce is drawn from a wide variety of ethnic backgrounds. The percentage of staff from Black and Minority Ethnic (BME) backgrounds is higher than the local population. 52% of staff who have disclosed their ethnicity are from BME groups. This was the same last year. White people make up 48% of the workforce compared to 72% of the London population.
  Age - 82% of our staff are 25 to 54. There have been no significant changes in regards to age since 2010/11.
  Gender - The workforce split in regards to gender has remained unchanged in the last 5 years: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations, reflecting the gender split of people entering healthcare professions.

- **Trust Board Composition**
  The trust Board of Directors comprises 12 people. White people account for 92% of Board Directors compared to 48% of the workforce as a whole. In regards to gender, 70% of the Board are men and 20% are women compared to the overall trust composition of 29% male and 71% female.

- **Data Quality**
  Workforce information on disability, sexual orientation and religion has improved since last year. The trust now holds demographic information on 56% (up from 47% in 2014/15) of all staff disability status and 60% (up from 54% in 2014/15) on sexual orientation and religion. The quality of data for new starters in 2015/16 has also improved since the previous year. This now stands at 90% and above for all three protected characteristics.

- **Recruitment**
  The trust receives almost as many white UK and white European applications (28%) as those of black African, black Caribbean and other black ethnic groups (30%). White people are however more likely to be successful at interview than people from BME backgrounds.

- **Access to training**
  Access to training provided by the trust is monitored by the Education and Learning Department. Access to trust delivered courses is broadly in line with the workforce composition. When the data is cut by gender, women were more likely to access training than men (by 7%) – but this is a slight fall from the previous year when it was 10%.

- **Performance ratings**
  A disproportionate number of poor performance ratings were awarded to people from BME backgrounds (66%) compared to 52% of the workforce. D or E ratings have been

awarded to less than 1% of our workforce.

- **Promotions and Leavers**
  White British staff were more likely to leave than other ethnic groups, accounting for 35% of leavers in 2015/16. When the data is split by gender, women are more likely to leave than men. The proportion of promotions is largely in line with trust population when split by ethnicity. Women were marginally more likely to be promoted than men.

- **Application of workforce procedures**
  In 2015/16, there were 77 formal disciplinary cases, twenty-six (32%) involved Asian, twenty-one (28%) involved black people and fourteen (19%) involved white people. Similar patterns exist in other organisations. Other factors influencing involvement in formal workforce hearings are seniority and gender.

- **Current and future initiatives to mitigate disproportionality include:**

	Summary of action	Owner
ACTION 1	An internal transfers scheme for nurses and midwifes will be introduced. Access to this will be monitored and ethnic breakdown will be reviewed.	Resourcing
ACTION 2	Band 5 rotation scheme will be offered and access to this monitored and reviewed.	Talent
ACTION 3	Band 6 development programme will be offered and access to this will be monitored and reviewed.	Nursing Directorate
ACTION 4	Capacity of trust leadership courses will be increased and access to these reviewed by ethnicity.	Talent
ACTION 5	Review of the apprentice scheme to ensure that it is promoted and accessible to our local population.	Talent
ACTION 6	We will continue to monitor interview panel membership to check that at least one panel member has been trained in recruitment and selection.	Resourcing
ACTION 7	The recruitment and selection training content will be reviewed to raise awareness of unconscious bias and best practice at interview.	Resourcing
ACTION 8	The Employee Relations team will continue to train managers in fair and equitable application of workforce policies.	ERAS
ACTION 9	Managers will be reminded to ensure to provide a good on-boarding and induction experience for all new starters by email when appointment is confirmed to them by the resourcing team.	Talent
ACTION 10	We will report on access to courses offered by universities when this is available for review.	Resourcing

ACTION 11	Additional support will be offered to managers to help them understand the results of the engagement survey and design appropriate action.	Talent
ACTION 12	We will review access to trust coaching and mentoring registers to establish whether positive action to ensure that this is accessed by BME people is required.	Talent
ACTION 13	We will train more managers in addressing bullying and harassment.	ERAS
ACTION 14	We will review the equality and diversity policies of search teams we engage with for the purpose of Board level candidate searches.	Resourcing

Imperial College Healthcare NHS
NHS Trust

Annual Workforce Equality and Diversity Report 2015/2016

(Incorporating Workforce Race Equality Standard)

Sebastiano Rossitto, Deyae Sefri and Martyna Ciastek

Directorate of People and Organisational Development

July 2016

1. Introduction

This report is published to help Imperial College Healthcare NHS Trust meet the public sector equality duty, as outlined in the Equality Act 2010. In addition, this report provides information required by the Workforce Race Equality Standard.

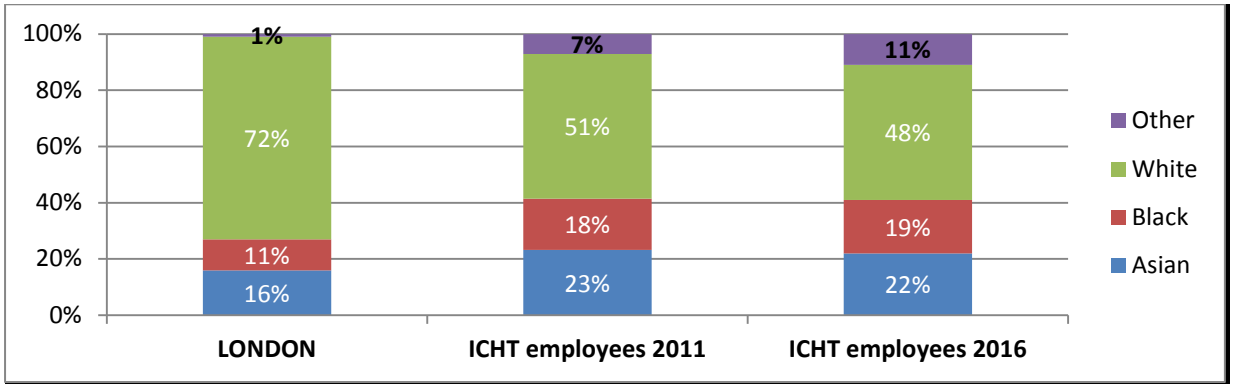
An action plan to mitigate any disproportionality can be found in appendix 1.

2. Workforce Composition

2.1 Ethnicity

The percentage of staff employed by the Trust from Black and Minority Ethnic (BME) backgrounds is higher than the local population. Fifty two percent of staff who disclose their ethnicity are from BME backgrounds compared to 28% of the London population. White people make up 48% of the workforce compared to 72% of the London population. The proportion of people from white backgrounds has decreased from 51% in 2011.

Fig. 1 London, local population and Trust ethnicity profile



Note: for the purpose of this Figure, data of “unknown” and “not stated” ethnicity is excluded.

When the workforce ethnicity data is split by clinical and non-clinical staff, it is largely comparable within bands. The majority of people in junior roles are from BME backgrounds. This changes with seniority as the majority of people in bands 7 and above are from white backgrounds.

There are a number of interventions that the Trust will be putting in place to support career management, including development of our staff, as well as better systems for internal transfers. The impact of this will be monitored to see how this can support ethnic distribution within bands that is more representative of our workforce.

Tab 1 Ethnicity profile – percentage of staff in each of the AfC bands and Very Senior Managers – March 2016

	Clinical				Non-Clinical			
	BME	White	Unknown	Count	BME	White	Unknown	Count
Band 1	0%	0%	0%	0	100%	0%	0%	2
Band 2	68%	29%	3%	628	60%	33%	7%	233
Band 3	64%	31%	5%	452	61%	35%	4%	685
Band 4	51%	43%	6%	149	45%	48%	7%	374
Band 5	62%	34%	5%	1714	51%	45%	5%	289
Band 6	58%	39%	3%	1645	44%	54%	2%	232
Band 7	38%	57%	4%	981	37%	57%	5%	134
Band 8a	25%	70%	4%	314	31%	62%	7%	99
Band 8b	19%	79%	2%	102	21%	78%	1%	87
Band 8c	9%	86%	5%	43	18%	75%	7%	60
Band 8d	0%	100%	0%	19	11%	77%	11%	61
Band 9	11%	89%	0%	9	11%	79%	11%	19
VSM	28%	51%	21%	2430	9%	78%	7%	51
Total Count		_		8486		_		2326

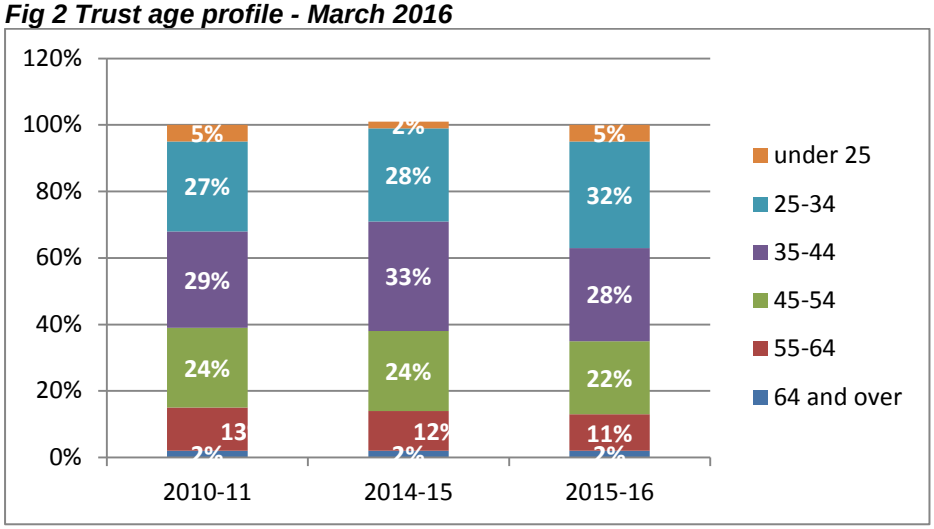
2.2 Workforce Composition: Age

There have been no significant changes in the workforce composition in regards to age since 2010/11. The majority of our staff, 82%, are aged 25 to 54.

The most noticeable variation can be seen amongst people aged 34 and below. Currently, 37% of our staff are within this age group compared to 33% in 2014/15 and 32% in 2010/11.

The Trust seeks to increase its attractiveness to people of all age groups through a range of measures including the widespread provision of work experience opportunities and apprenticeships and the promotion of flexible working.

Fig 2 Trust age profile - March 2016

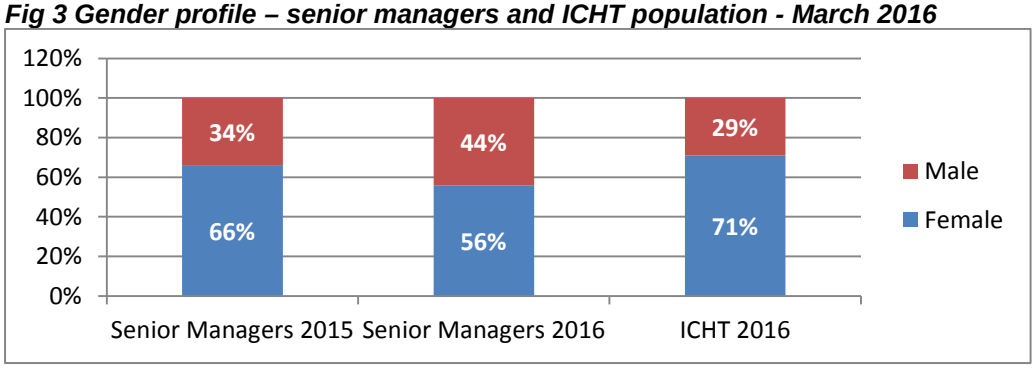


2.3 Workforce Composition: Gender

The workforce split in regards to gender has remained unchanged in the last 5 years: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations, reflecting the gender split of people entering healthcare professions.

The proportion of male employees increases in more senior roles. The figure below shows that 44% of people employed as senior managers are men and 56% are women. This is a significant change from last year when 34% of senior managers were men and 66% were women.

Fig 3 Gender profile – senior managers and ICHT population - March 2016

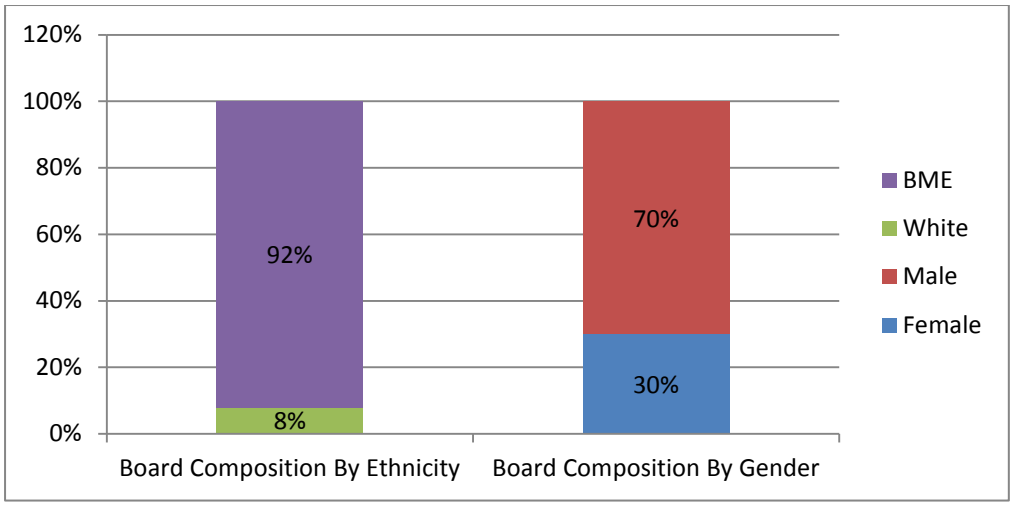


2.4 Trust Board of Directors Composition: gender and ethnicity

The Board of Directors comprises 12 people. White people account for 92% of Board Directors compared to 48% of the workforce as a whole. 70% are men and 30% are women compared to the overall Trust composition of 29% male and 71% female.

This is an important area of review for the Trust. We will review the equality and diversity policies of the talent sourcing providers we use for board executive recruitment to ensure that they are fair, equitable and transparent.

Fig 4 Trust Board composition by gender and ethnicity



2.5 Data quality for disability, sexual orientation and religion - 2015/16

Workforce information on disability, sexual orientation and religion has improved since last year. The Trust now holds demographic information on 56% (up from 47% in 2014/15) of all staff disability status and 60% (up from 54% in 2014/15) on sexual orientation and religion.

The quality of data for new starters in 2015/16 has also improved since the previous year. This now stands at 90% and above for all three protected characteristics.

The data capture is 100% for new starters whose applications are recorded via the Trac recruitment system. There are staff groups where this facility is not yet available resulting in an incomplete overall capture of data on new starters. There are plans to roll Trac out to all staff groups in the future the replace the current facilities which are less reliable.

Tab 2 Disability, sexual orientation and religion records for all staff including new staff

Protected Characteristic	Recorded demographic for all staff in 2013/14	Recorded demographic for NEW staff in 2013/14	Recorded demographic for all staff in 2014/15	Recorded demographic for NEW staff in 2014/15	Recorded demographic for all staff in 2015/16	Recorded demographic for NEW staff in 2015/16
Disability	40%	95%	47%	89%	56%	92%
Sexual Orientation	46%	96%	54%	88%	60%	90%
Religion	46%	96%	54%	88%	60%	90%

3. Recruitment

The Trust monitors the progress of applicants through the selection process by protected characteristic. A summary of the monitoring information is shown in tables 3-9.

3.1 Recruitment by ethnicity

The Trust receives almost as many white UK and white European applications (28%) as those of black African, black Caribbean and other black ethnic groups (30%). Applicants from Asian ethnic groups account for 19% of all applicants. Shortlisting is anonymous. The conversion rate from shortlisting to appointment is higher for white British or European overall than any other ethnic group, most notably for white Irish and white British applicants. The conversion for mixed race applicants is one of the highest although applicants in this group only account for 5.81% of the total. Black African applicants are the least likely group to be appointed following shortlisting.

Tab 3 Recruitment analysis by ethnicity

	Applicants	Shortlisted	Appointed
White British	15.45%	17.31%	26.69%
White Irish	1.27%	2.27%	3.67%
Any other white background	11.62%	12.94%	11.28%
Asian or Asian British Indian	10.31%	9.21%	7.73%
Asian or Asian British Pakistani	4.01%	2.95%	3.26%
Asian or Asian British Bangladeshi	4.74%	3.27%	2.63%
Any other Asian background	6.89%	7.38%	7.27%
Black or Black British - Caribbean	7.04%	6.35%	5.38%
Black or Black British - African	20.79%	19.38%	11.97%
Any other Black background	2.71%	1.81%	2.92%
Mixed White & Black Caribbean	1.12%	1.09%	0.92%
Mixed White & Black African	1.14%	1.09%	0.40%
Mixed White & Asian	0.74%	0.70%	0.52%
Any other mixed background	2.81%	2.96%	4.30%
Chinese	0.99%	1.15%	1.49%
Any other ethnic group	4.80%	5.37%	4.30%
Not stated	3.37%	3.21%	4.81%

3.2 Relative likelihood of being appointed from shortlisting

Tab 4 Likelihood of being appointed from shortlisting by ethnicity – 2015/16

Descriptor	White	BME
Number of shortlisted applicants	4193	8084
Number appointed from shortlisting	727	930
Relative likelihood	0.17	0.12

The likelihood of white people being appointed from shortlisting is 0.17 and 0.12 for BME groups. The relative likelihood of white people being appointed from shortlisting compared to BME people is therefore 1.42 greater. This is a significant change from the previous year when the relative likelihood was 5 times greater for white people than for BME people. This may be accounted for by the refreshed approach to advertising jobs aimed at attracting a greater diversity of applicants. In the last year, the Trust has used a varied range of vacancy advertising channels, including LinkedIn and Twitter, in addition to the traditional use of NHS Jobs. What is more, actions were put in place to ensure that the disproportionality noted last year is highlighted to managers, such as revision of training. This is an area that we will continue to review and note really good progress this year.

Recruitment analysis by gender shows that conversion rates for female applicants are slightly higher than for male applicants; this could in part be accounted for by the larger volume of female applicants.

Tab 5 Recruitment analysis by gender 2015-16

Gender	Applicants	Shortlisted	Appointed
Male	32.31%	26.18%	25.95%
Female	67.24%	73.40%	73.94%
Not stated	0.44%	0.42%	0.11%

Analysis by transgender shows conversion rates broadly in line with the breakdown of applicants.

Tab 6 Recruitment analysis by transgender 2015-16

Transgender	Applicants	Shortlisted	Appointed
No	17.70%	20.90%	32.93%
Yes	0.10%	0.10%	0.17%
Not stated	81.60%	78.28%	65.86%

Analysis by religion, age, sexual orientation and disability shows that conversion rates from shortlisting to appointment are broadly in line with the breakdown of applicants.

Tab 7 Recruitment analysis by age 2015-16

Age group	Applicants	Shortlisted	Appointed
Under 20	1.08%	0.57%	**0.34%**
20 - 24	19.70%	16.24%	**20.50%**
25 - 29	25.21%	24.44%	**27.72%**
30 - 34	16.19%	16.27%	**15.81%**
35 - 39	12.37%	13.00%	**12.60%**
40 - 44	8.60%	10.22%	**8.53%**
45 - 49	7.58%	8.91%	**6.19%**
50 - 54	5.68%	6.16%	**4.75%**
55 - 59	2.73%	3.19%	**2.46%**
60 - 64	0.73%	0.81%	**0.63%**
65+	0.10%	0.16%	**0.46%**
Not stated	**0.03%**	**0.02%**	**0.00%**

Tab 8 Recruitment analysis by disability 2015-16

	Applicants	Shortlisted	Appointed
No	95.26%	94.83%	**91.75%**
Yes	3.43%	3.55%	**3.67%**
Not stated	**1.31%**	**1.61%**	**4.58%**

Tab 9 Recruitment analysis by religion 2015-16

Religion	Applicants	Shortlisted	Appointed
Atheism	6.78%	7.94%	**12.32%**
Buddhism	1.15%	0.96%	**1.12%**
Christianity	52.03%	56.39%	**51.06%**
Hinduism	7.74%	6.14%	**5.15%**
Islam	15.53%	11.47%	**9.63%**
Jainism	0.25%	0.22%	**0.34%**
Judaism	0.21%	0.28%	**0.22%**
Sikhism	1.27%	1.01%	**0.11%**
Other	5.55%	5.56%	**5.94%**
Do not wish to disclose	**9.50%**	**10.04%**	**14.11%**

Tab 10 Recruitment analysis by sexual orientation 2015-16

Gender	Applicants	Shortlisted	Appointed
Bisexual	1.05%	0.92%	**0.63%**
Gay	1.49%	1.67%	**2.23%**
Heterosexual	88.01%	86.94%	**85.74%**
Lesbian	0.46%	0.57%	**1.09%**
Not stated	**9.00%**	**9.99%**	**10.41%**

The Trust currently requires at least one interview panel member to be trained in recruitment and selection. In addition, all panel members are required to undertake Equality and Diversity training as this is mandatory for all people working at the Trust.

4. Access to non- compliance training 2015/16

Access to non-compliance training provided by the Trust's education and learning centre is monitored. Access to courses is monitored by the education and learning centre is broadly in line with the workforce composition.

When the data is cut by gender, women are more likely to access training than men within the organisation: women accessing training is 7% higher than the Trust workforce composition, but a slight fall from last year when it was 10% higher.

Access to training for people from most ethnic backgrounds is representative of the workforce composition. Black people however form 17% of the total workforce and 21% of those have accessed training. This is an increase on last year when 13% of black people accessed training within the Trust. Access to training by Asian staff is in line with their composition in the workforce at 21%.

Access to training by age group follows the age profile of the organisation.

The difference between the staff survey data and the data recorded by the Trust`s education and learning centre stems from the fact that most training to Trust staff is managed outside of the education and learning centre and is therefore not included in table 11 below. We will be able to capture this data in the future once we have procured an integrated learning management system (LMS). For the purposes of this report, data has been pooled from all vocational courses, PDR training for line managers, Great Conversations, Understanding Workforce Policies courses held in 2015/16: this is a greater number of courses used for this analysis than in the previous year. This data does not include Core Skills training (formerly Statutory and Mandatory) as this is required by all staff regardless of age, gender or ethnicity.

Tab 11 Access to training by gender, ethnicity and age 2016

GENDER		
Female	78.26%	70.89%
Male	21.74%	29.11%
ETHNICITY		
Asian	20.90%	20%
Black	21.15%	17.02%
Not stated	3.01%	3.97%
Other	9.70%	10.11%
Unknown	0.92%	4.68%
White British	28.93%	28.30%
White Other	15.38%	15.91%
AGE		

<25	3.99%	3.70%
25-44 years	60.40%	59.78%
45-54 years	23.63%	22.73%
55-64 years	10.32%	11.76%
64 years and over	1.66%	2.04%

4.1 Relative likelihood of accessing non-mandatory training

The likelihood of BME people accessing non mandatory training and CPD was 0.1153 and for white people it was 0.1285. The relative likelihood of BME people accessing non mandatory training and CPD was 1.1144 times greater than white staff. This is a change from the previous year when the relative likelihood of accessing training and CPD was greater for white people than BME people 1.2770 times. This may be accounted for by the fact that this year the Trust was able to report on access to a wider selection of training.

Tab 12 Access to non-mandatory training and CPD by ethnicity

Descriptor	Number of staff in workforce	Staff accessing non mandatory training and CPD	Likelihood of accessing non mandatory training
White	4674	539	0.1153
BME	3913	503	0.1285

5. People awarded D or E rating on Performance and Development Review (PDR)

PDR ratings have pay implications for people on Agenda for Change contracts because incremental pay increases are awarded to people who are given A, B or C ratings. Ninety four people (0.9% of the Trust population) were awarded D or E rating on PDR in 2015/16. A D or an E rating indicates that performance is unsatisfactory.

Figure 5 shows the data on people who were awarded a D or E rating on PDR cut by gender and ethnicity. When cut by gender, the proportions are broadly in line with overall workforce composition. However, when cut by ethnicity, people from BME backgrounds were more likely to be awarded a D or E rating. Sixty six percent of D and E ratings (0.05% of Trust population) were awarded to BME staff. The disproportionality has lessened since last year when BME people accounted for 71% of those who received a D or an E rating.

When the data on those who received D and E ratings is cut by grade and professional group, there is a disproportionately high number of band 5 and 6 nurses. Grade and professional group may be contributory factors for the high proportion of BME staff amongst those who received low performance ratings but even when these factors are taken into account, ethnicity may be a factor.

The Trust has just commenced the third year of conducting PDRs in line with this process. This is an important area of review to ensure that it is designed and followed robustly and is not open to bias. As a result of actions agreed following last year`s review, the mandatory PDR training for managers now covers the topic of unconscious bias and a reduction in the disproportionality has been noted. At the same time, this affects a very small number of our staff, less than 1% of the whole workforce.

Fig 5 People awarded D or E rating on PDR by gender and ethnicity 2015-16

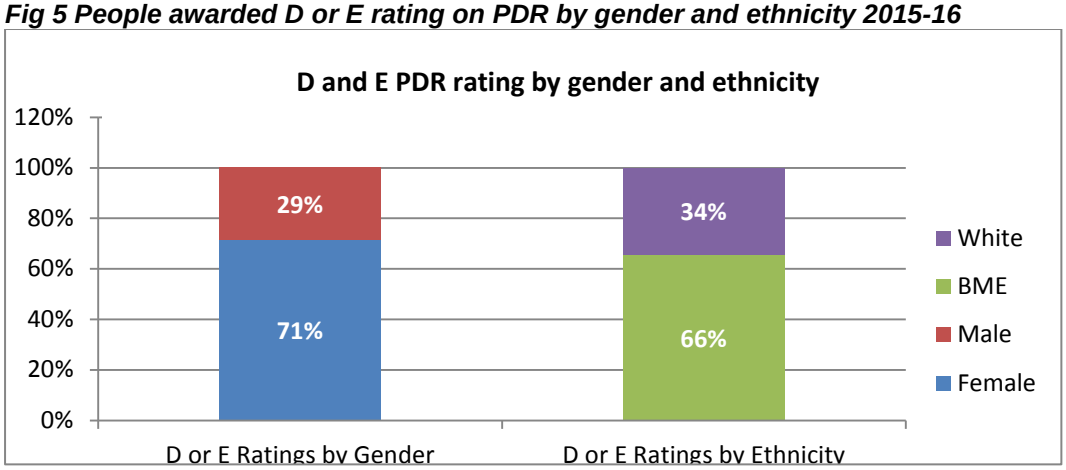


Fig 6 People awarded D or E rating on PDR by band 2015-16

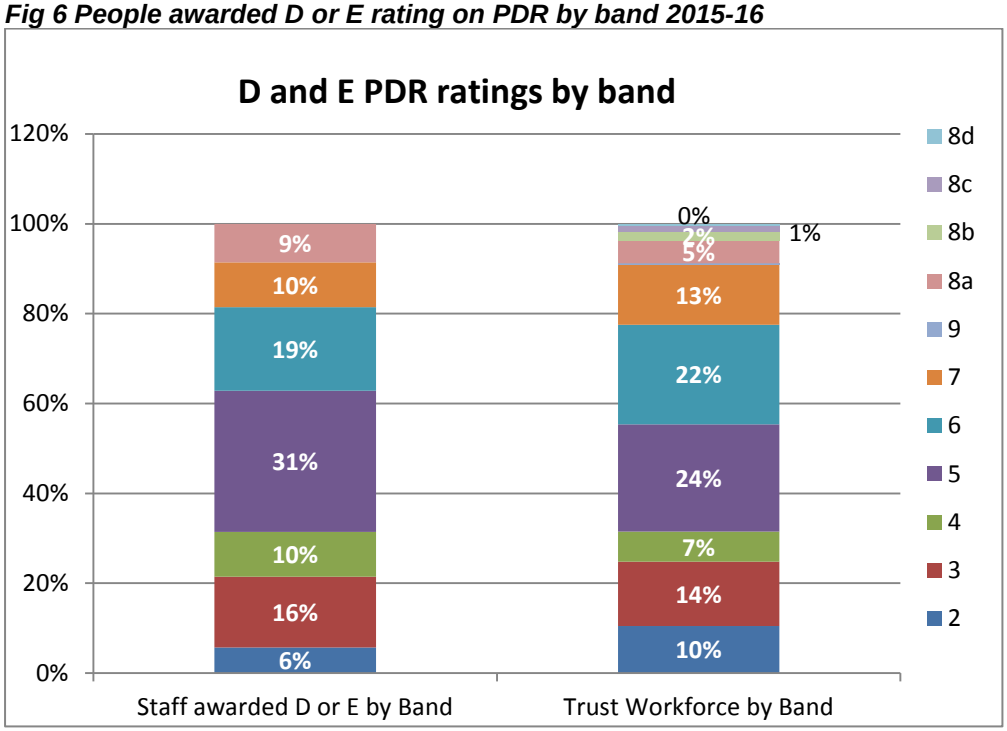
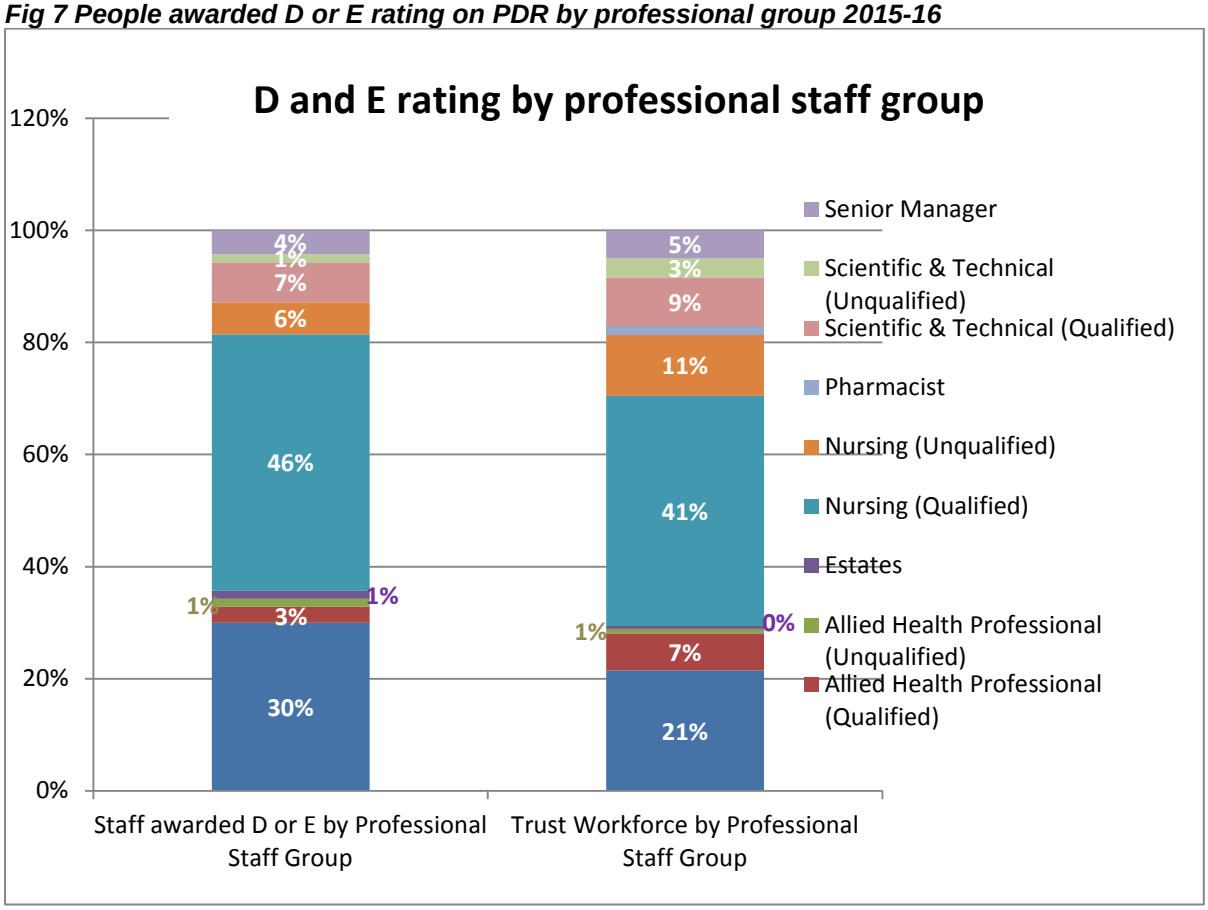


Fig 7 People awarded D or E rating on PDR by professional group 2015-16



6. Promotions and leavers

White British staff are more likely to leave than other ethnic groups, accounting for 35% of leavers in 2015/16. When the data is split by gender, women are more likely to leave than men – men accounted for 25% of leavers compared to 29% the workforce. This is a significant change from last year when 36% of leavers were men.

People from white backgrounds accounted for 50% of promotions and BME people for 49%. This is comparable to the Trust population where BME people account for 52% and white people account for 48% of the workforce. When promotions are cut by gender, women are marginally more likely to be promoted than men.

Fig 8 Promotions and leavers by ethnicity 2015-16

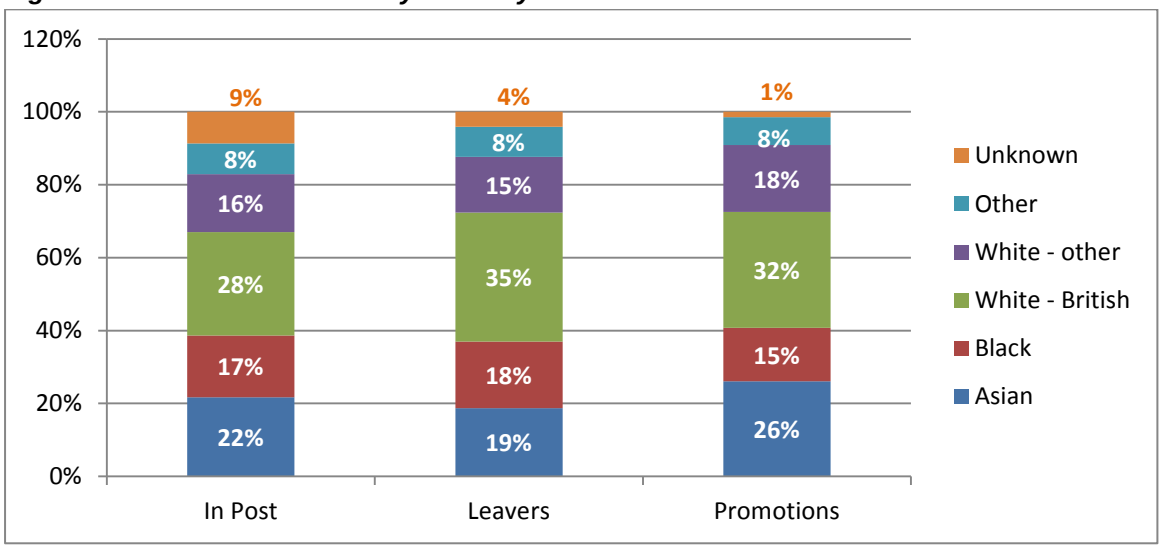
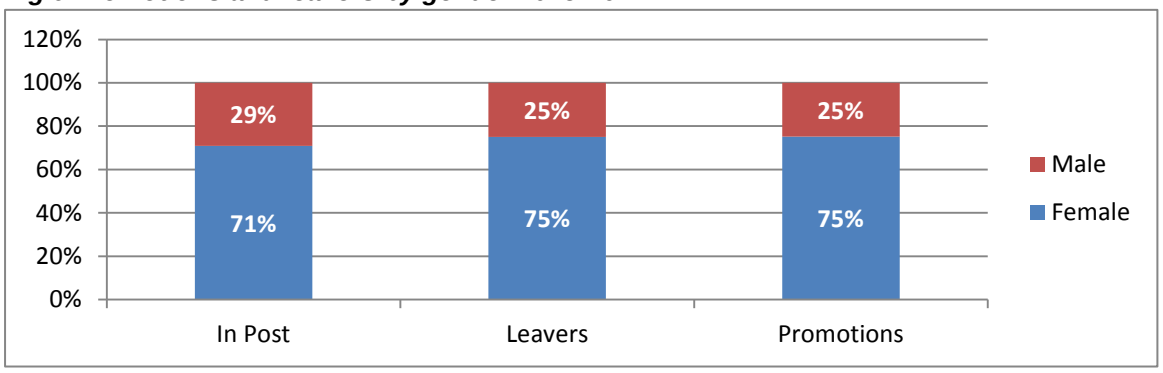


Fig 9 Promotions and leavers by gender 2015-16



7. Application of formal workforce procedures 2015/16

The Trust monitors the formal application of workforce procedures by ethnicity, gender and age. In 2015/2016, there were 254 formal hearings in total.

7.1 Ethnicity

In 2015/16, there were 77 formal disciplinary cases, twenty-six (32%) involved Asian, twenty-one (28%) involved black people and fourteen (19%) involved white people.

In 2015/16, there were 20 formal performance management cases. Comparing the performance participation rates against the Trust population, table 13 shows that black people who made up 17% of the workforce accounted for 30% of performance hearings. The disproportionate involvement of black people is down from 2014/15 when black people accounted for 46% of performance hearings and 20% of the workforce.

In 2015/16, there were 136 formal sickness absence cases, both long term and short term, of which 38% involved white people. There were also 21 formal grievance hearings, of which seven (33%) involved white people, eleven (53%) involved BME people.

Tab 13 Formal hearings by ethnicity 2015/2016

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Ethnicity	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Asian	22%	24	32%	3	15%	25	18%	4	19%
Black	17%	21	28%	6	30%	32	24%	5	24%
White	44%	14	19%	5	25%	51	38%	7	33%
Other	8%	7	9%	4	20%	19	14%	2	10%
Not stated	9%	9	12%	2	10%	9	7%	3	14%
Total	100%	75	100%	20	100%	136	100%	21	100%

Table 14 suggests that both grade and ethnicity are factors influencing participation in formal workforce procedures. Junior people from all ethnic groups are more likely to be involved in formal procedures than senior people. In 2015/16, people employed in band 2-5 roles accounted for 43% of the total workforce and 70% of formal workforce procedures. Amongst them, band 3 and band 5 accounted for the majority of the cases but also there is a higher proportion of employment in these bands. Considering the population of employment in each band amongst band 2-5, band 2 and band 4 have a higher likelihood of being involved in formal workforce procedures. As BME people represent a higher proportion of employment in these bands (band 2-5), higher participation rates for junior people will result in higher participation rates for certain ethnic groups. However, grade only offers a partial explanation: even allowing for the impact of grade, BME people are still more likely to be the subject of formal workforce procedures.

The Trust delivers training sessions to ensure that managers are appropriately trained in application of workforce policies, including the disciplinary policy. These sessions have been recently reviewed. They focus on fair application of the policies and raise awareness of unconscious bias. We realise that on-boarding and a positive relationship with the line manager and the team plays an important role here. Going forward, we will remind managers about the importance of thorough induction as part of the boarding process.

Tab 14 Formal hearings by ethnicity and band 2015/16

Band	No of meetings involving white people	% of meetings involving white people	% of white people by band in workforce	No of meetings involving BME people	% of meetings involving BME people	% of BME people by band in workforce
2	14	6%	2%	19	8%	5%
3	14	6%	4%	33	14%	7%
4	9	4%	2%	15	7%	2%
5	13	6%	7%	44	19%	11%
6	15	7%	7%	30	13%	10%
7	9	4%	6%	9	4%	4%
8 and above	3	1%	5%	1	0%	2%
Medical & Dental	0	0	10%	1	0%	6%
Total	77	34%	43%	152	66%	47%

Note: for the purpose of this table, 23 meetings involving people of "not stated" ethnic status were excluded.

7.2 Relative likelihood of entering into formal disciplinary procedure

Table 15 shows that the likelihood of BME people entering the formal disciplinary procedure over the two year rolling period from April 2014 to March 2016 was 0.0116 and for white people it was 0.0057. Therefore the relative likelihood of BME staff entering the formal disciplinary procedure, compared to white people was 2.03 times greater. This year is the first year when we are able to benchmark our performance against other trusts on this Workforce Race Equality Standard (WRES) measure.

Tab 15 Likelihood of entering the formal disciplinary hearing by ethnicity – two year average 2014-16

Descriptor	Average number of staff in workforce (2014-16)	Annual average of number of formal disciplinary meetings (2014-16)	Relative likelihood of entering formal disciplinary meetings
White	**4556**	**26**	**0.0057**
BME	**5000**	**58**	**0.0116**

7.3 Gender

Comparing the figures against the Trust population, table 16 shows that men are more likely than women to be subject to disciplinary actions. Women are more likely than men to be

involved in other workforce procedures, including sickness, performance management and grievance. We have observed this trend over the recent years.

Tab 16 Formal hearings by gender 2015/2016

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Gender	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Female	71%	46	61%	16	80%	113	83%	19	90%
Male	29%	29	39%	4	20%	23	17%	2	10%
Total	100%	75	100%	20	100%	136	100%	21	100%

7.4 Age

The 25-34 age group had the highest participation rates for disciplinary, performance management and sickness formal procedures; however, it is also the largest age population amongst the Trust workforce. The 55-64 age group were the most likely to raise grievances.

Tab 17 Formal hearings by age 2015/2016

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Age group	% of Trust population	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Under 25	5%	3	4%	0	0	5	4%	2	10%
25-34	32%	22	29%	6	30%	39	29%	3	14%
35-44	28%	15	20%	5	25%	39	29%	5	24%
45-54	22%	18	24%	5	25%	32	24%	0	0
55-64	11%	13	17%	4	20%	17	13%	11	52%
65 and over	2%	4	5%	0	0	4	3%	0	0
Total	100%	75	100%	20	100%	136	100%	21	100%

8. Staff experience: 2015 NHS Staff Survey Results

The Trust monitors staff experience by protected characteristics through the annual NHS Staff Survey. The 2015 staff survey results revealed some differences in experience when analysed by disability status, ethnicity, age and gender.

The full results of the 2015 staff survey can be found at http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results/.

8.1 Gender

There are few significant differences in experience by gender. Overall men respond less positively to some questions relating to personal development and access to training, as well as opportunities to maintain health, well-being and safety.

Women, on the other hand, were more likely to report experiencing harassment, bullying or abuse or feeling pressurised to attend work when unwell than men.

Women are overall more engaged than men with engagement scores of 3.79 and 3.60, respectively.

8.2 Disability

People with disabilities and those who do not report to have a disability provide similar answers to the majority of KFs. Where the responses differ significantly, they are typically less favourable for disabled people.

Disabled people provide less favourable responses to questions relating to opportunities to maintain health, well-being and safety. For example disabled people were more likely than non-disabled people to report work related stress in the last 12 months (56% compared to 38%). Disabled people are also more likely to report feeling less engaged with decisions that affect staff and services they provide and empowering them to put forward ways to deliver better services.

The engagement score, is higher for non-disabled people (3.55) than disabled people (3.24).

8.3 Age

People of all age groups report similar experiences on the majority of the KFs. The area where responses differ most significantly relates to violence and harassment. This is most frequently reported by people below the age of 30. The age group 31-44 were the least likely to report this. People under 30 were also the least likely group to report positively on being satisfied with opportunities for flexible working or feeling that their opinions can lead to improvements in the workplace.

The most engaged staff group when split by age are people aged 51 and over with an engagement score of 3.93. The least engaged group are people aged 16-30 with an engagement score of 3.67.

8.4 Ethnicity

When the data is split by ethnicity, the biggest variation is on questions relating to equality and diversity and satisfaction with quality of work and patient care. BME people were more likely to report experiencing discrimination at work (32% BME, 8% white) or believing that the organisation provides equal opportunities for career progression (65% BME, 86% white people). However, BME people report more positively than white people on the quality appraisals. They also feel less pressurised to come to work when unwell (47% BME, 57% white).

Overall, BME and white staff responses indicate a similar overall engagement level. The scores are 3.74 and 3.75 respectively. This is a change from last year when the engagement score for BME people was 3.86. The engagement score for white people remained unchanged.

8.5 NHS National Survey questions mandated by the WRES.

Under the Workforce Race Equality Standard the Trust is required to publish the responses cut by ethnicity to the following NHS staff survey results:

Tab 18: Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

White	*BME*
25%	32%

Tab 19: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

White	*BME*
28%	35%

Tab 20: Percentage of staff who believe that trust provides equal opportunities for career progression or promotion.

White	*BME*
86%	65%

Tab 21: In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.

White	*BME*
5%	22%

9. Progress on actions agreed last year

A number of actions were agreed by managers, staff and staff side colleagues following the analysis of the data contained in last year`s report. Actions and the progress relating to them are noted below:

1. The data on the disproportionate award of E and D ratings at Performance & Development Review will be inform the mandatory PDR training for managers to raise awareness and challenge unconscious bias.

   This action was completed. Mandatory PDR training for managers now includes a section to raise awareness of unconscious bias. In the 2014 PDR cycle, 75% of those issued unsatisfactory D or E ratings were BME. This decreased to 66% in 2015. Further analysis is available in section 6. We will continue to observe and analyse the data once the 2016 PDR cycle is complete.

2. BME applicants are less likely to be shortlisted and appointed than their white counterparts. The recruitment team will undertake a review of interview panel membership to ensure that panel members are appropriately trained and review mandatory recruitment and selection training to ensure that unconscious bias is appropriately covered. Further analysis of the data will be carried out to better understand the different conversion rates for white and BME people in the recruitment process.

   The review of the recruitment and selection training has been completed.

   The review of interview panel membership has been completed. Some services are more compliant than others but the overall complacence stands at 40%. There were a total of 1783 interviews in 2015/16 and 714 of those had at least one person trained in recruitment and selection on the panel. The recording of interview panel membership against completion of recruitment and selection training is relatively new and further work is required to increase compliance.

   However, the likelihood of being appointed from shortlisting has increased for both white and BME applicants. Last year, the likelihood of white people being appointed from shortlisting was 0.15. This year, it is 0.17. The increase in likelihood has been significant for BME people. In 2014/15, this stood at 0.03 and has increased to 0.12 in 2015/16.

3. The quality of demographic data for new starters has dropped in 2014/15. The recruitment team will review its processes to ensure that the demographic status of at least 95% of new starters is captured.

   The quality of data has improved. Data on 92% of new starters ‘disability status and 90% of new starters` sexual orientation and religion has been captured. A further review of the processes is required to reach the agreed target of 95%.

4. We currently report on equal pay within bands by gender (fig 16). We will run a similar report on ethnicity to determine whether there are significant differences within grade.

   This review has been completed. When the data on pay was split by ethnicity, this did not indicate disproportionality.

5. The Trust does not currently report on access to training for nurses and midwives because the data is held by universities. This data will be collated, analysed and reported on and action will be taken to address any evidence of differential access by protected characteristic.

   This data has been analysed partially as only data on courses where the Trust receive direct funding is available in a format that can be analysed. The review showed that in 2015/16, 75 people accessed training via this route. When the data was split by age, it was broadly in line with Trust population. Analysis by gender and ethnicity shows some disproportionality – women (88%) were more likely to access this type of training than men (12%). This can be accounted for by the fact that the large amount of people accessing this training were in nursing and midwifery roles, where the majority of staff are female. Splitting the data by ethnicity showed that 57% of people were white and 43% were BME. This is different to the workforce population of 48% white and 52% BME.

In addition, the Trust uses the NHS Equality Delivery System 2 (EDS2) framework to fulfil its public sector equality duty to promote equality. In 2015/16 the Trust's EDS2 workforce focus was on training and development opportunities and equal pay for work of equal value. This year`s focus is on flexible working opportunities being equitably available to people. For last year`s grading, please follow this link:

file://clw-vfandp-001/User01/cm149/Personal%20Profile/Downloads/Equality%20Delivery%20System%202%20%20grading%20memo%20(2).pdf.

Appendix 1 Annual Workforce report Action Plan for 2016/17

	Summary of action	Owner
ACTION 1	An internal transfers scheme for nurses and midwifes will be introduced. Access to this will be monitored and ethnic breakdown will be reviewed.	Resourcing
ACTION 2	Band 5 rotation scheme will be offered and access to this monitored and reviewed.	Talent
ACTION 3	Band 6 development programme will be offered and access to this will be monitored and reviewed.	Nursing Directorate
ACTION 4	Capacity of Trust leadership courses will be increased and access to these reviewed by ethnicity.	Talent
ACTION 5	Review of the apprentice scheme to ensure that it is promoted and accessible to our local population.	Talent
ACTION 6	We will continue to monitor interview panel membership to check that at least one panel member has been trained in recruitment and selection.	Resourcing
ACTION 7	The recruitment and selection training content will be reviewed to raise awareness of unconscious bias and best practice at interview.	Resourcing
ACTION 8	The Employee Relations team will continue to train managers in fair and equitable application of workforce policies.	ERAS
ACTION 9	Managers will be reminded to ensure to provide a good on-boarding and induction experience for all new starters by email when appointment is confirmed to them by the resourcing team.	Talent
ACTION 10	We will report on access to courses offered by universities when this is available for review.	Resourcing
ACTION 11	Additional support will be offered to managers to help them understand the results of the engagement survey and design appropriate action.	Talent
ACTION 12	We will review access to Trust coaching and mentoring registers to establish whether positive action to ensure that this is accessed by BME people is required.	Talent
ACTION 13	We will train more managers in addressing bullying and harassment.	ERAS
ACTION 14	We will review the equality and diversity policies of search teams we engage with for the purpose of Board level candidate searches.	Resourcing

Appendix 2 GLOSSARY OF TERMS USED IN THIS REPORT

Not stated	Answer to the question about demographic status was not provided
I do not wish to disclose	Person chose not to disclose demographic status
Unknown	A combination of Not stated and Unrecorded
Senior Managers	This includes people in bands 8-9, very senior managers and senior managers and senior medical staff
PDR	Performance and Development Review
New Starters	People who began working for the Trust between April 2014 and March 2015
Non-clinical support	Admin & Clerical, Estates and senior managers
Clinical support	Unqualified, Nurses, Scientific and Technical (S&T) and Allied Health Professionals (AHP)
Scientific & Technical	Qualified Scientific & Technical and pharmacists
BME	Black & Minority Ethnic
White	A combination of White British and White Other
Promotions	People who have an upward change of band/grade during the reporting year and are still employed at the end of the reporting year.

Appendix 3 Cross-referencing the Workforce Race Equality Standard requirements with the Annual Workforce Equality and Diversity Report

	Indicator **For each of these nine workforce indicators, data is compared for white and BME staff**	Section of the report
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce (split by clinical and non-clinical staff).	2.1
2	Relative likelihood of staff being appointed from shortlisting across all posts.	3.2
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (a two year rolling average of the current year and the previous year).	7.2
4	Relative likelihood of staff accessing non-mandatory training and CPD.	4.1
5	Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	8.5
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	8.5
7	Percentage of staff who believe that trust provides equal opportunities for career progression or promotion.	8.5
8	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.	8.5
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	2.4

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Finance & Investment Committee (19 August & 21 September)**

KEY ITEMS TO NOTE

The Committee noted :

- That months 4 and 5 positions were slightly better than plan, with a full year forecast of achieving the planned deficit of £52m.
- The latest control total discussions, particularly noting that the Trust board would be asked to consider whether the Trust should accept the revised total and the risks attached to this.
- The significant progress achieved by the divisional teams in relation to the financial improvement programme, and the contributed made by PwC in achieving this. Further opportunities continued to be identified, and firm plans created.
- The proposals for the revised NHS Improvement single oversight framework; this was the subject of agenda item 5.1.

The Committee reviewed post project evaluations for:

- Cerner, the electronic patient record system implemented across the Trust – objectives had been achieved in line with the planned delivery dates at lower than planned implementation costs.
- The managed service contract for medical equipment – a number of lessons learned in the implementation of this contract had been implemented in later contracts (eg the 'hard' facilities management contract).
- Patient transport – where the service has improved, but further improvements were sought
- The Committee requested an independent view be included in future evaluations.

The Committee approved:

- The submission of the joint expression of interest, with Chelsea and Westminster, in becoming a Centre of Global Digital Excellence; the focus of such centres would be to improve processes of care; and use information to better inform the decision making process.
- The proposed revisions to the treasury management policy and the expenses and travel policy
- The revised terms of reference.
-

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: 23 November 2016

Imperial College Healthcare NHS Trust

Report to:	**Trust board**
Report from:	**Redevelopment committee report (21 September 2016)**

KEY ITEMS TO NOTE

The Committee noted continued progress for developing the St Mary's site; in particular the possibilities in relation to the development of the 'triangle building' as a new and comprehensive out-patient and diagnostic environment. The Committee considered a draft strategic outline business case which would need approval by the Trust board, NHS Improvement and NHS England.

They also noted the continuing discussions that had been held with both Sellar and the Westminster planning office in relation to the Trust's plans, and reflecting on the application submitted for the 'cube'.

The Committee received a report on the engagement programme launch, focusing on the three-day public exhibition held on 8-10 September, which had received a mainly positive response from those who visited and provided feedback. This is subject covered in a separate board paper (item 4.4).

The Committee also noted to on-going discussions with NHS Improvement and NHS England in relation to development of an appropriate business case.

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:	TBC, October 2016