

# Statement of Cash Flow Forecast - Mth 10

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CASHFLOW FORECAST - MOST LIKELY																	
COMBINED ANNUAL CASH FLOW	Jan '16	Jan '16	Feb '16	Mar '16	Forecast	Plan	Apr'16	May'16	Jun'16	Jul'16	Aug'16	Sep'16	Oct'16	Nov'16	Dec'16	Jan'16	Rolling forecast
ACTUAL & FORECAST (k)	Forecast	Actual	Forecast	Forecast	Apr'15 - Mar'16	Apr'15 - Mar'16	Apr'16	May'16	Jun'16	Jul'16	Aug'16	Sep'16	Oct'16	Nov'16	Dec'16	Jan'16	Feb'16 - Jan'16
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance brought forward from prior month	12,265	12,265	13,246	14,945	14,189	14,189	24,128	24,843	23,758	22,648	20,965	19,388	14,136	16,766	14,916	14,186	13,686
<b>RECEIPTS</b>																	
SLA Income & Sundry NHS	33,117	32,237	34,000	34,180	392,147	355,875	31,704	31,704	31,704	31,704	31,704	31,704	31,704	31,704	31,704	31,704	385,220
VAT	500	1,052	779	500	7,256	5,318	500	500	500	500	500	500	500	500	500	500	6,279
Receipts in advance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other income (inc bank Interest)	7,710	6,704	7,196	7,710	85,997	77,121	3,618	3,618	3,618	3,618	3,618	3,618	3,618	3,618	3,618	3,618	51,085
Capital Receipts	0	0	0	13,975	16,668	10,460	1,800	0	0	0	0	0	4,500	0	0	0	20,275
DoH Capital Loan	0	0	0	1,478	6,830	6,830	0	0	0	0	0	0	0	0	0	0	1,478
<b>TOTAL</b>	<b>41,326</b>	<b>39,993</b>	<b>41,975</b>	<b>57,843</b>	<b>508,898</b>	<b>455,605</b>	<b>37,622</b>	<b>35,822</b>	<b>35,822</b>	<b>35,822</b>	<b>35,822</b>	<b>35,822</b>	<b>40,322</b>	<b>35,822</b>	<b>35,822</b>	<b>35,822</b>	<b>464,337</b>
<b>PAYMENTS</b>																	
Creditors NHS	5,235	4,531	6,357	9,079	62,964	44,922	3,607	3,607	3,607	3,607	3,607	3,607	3,607	3,607	3,607	3,607	51,505
Creditors (BACS/Chaps and Payable Orders)	10,833	11,139	8,416	9,672	118,377	84,456	5,283	5,288	5,313	5,333	5,294	5,273	5,268	5,248	5,213	5,213	70,810
Salaries & Wages (inc Chaps)	13,201	14,014	13,201	13,201	164,482	176,913	14,978	14,973	14,973	14,973	14,706	14,706	14,706	14,706	14,083	14,083	173,289
Pensions	4,076	4,072	4,076	4,076	48,809	52,498	4,735	4,735	4,735	4,735	4,653	4,653	4,653	4,653	4,460	4,460	54,624
Tax & NI	5,838	5,596	5,838	5,838	68,114	73,262	6,622	6,622	6,622	6,622	6,506	6,506	6,506	6,506	6,237	6,237	76,662
Redundancy payments	0	0	0	621	621	3,100	0	0	0	0	0	0	0	0	0	0	621
PDC/TDR/ Repayment	0	0	0	4,094	8,188	8,235	0	0	0	0	0	4,094	0	0	0	0	8,188
Loan Repayment- interest	0	0	20	0	20	0	0	0	0	0	39	0	0	0	0	0	59
Loan Repayment Capital	0	0	0	0	0	0	0	0	0	0	359	0	0	0	0	0	359
CG-revenue	700	1,140	700	700	9,298	0	700	700	700	700	700	700	700	700	700	700	8,400
TPP payments- revenue	68	41	68	68	231	0	69	69	69	69	69	69	69	69	69	69	830
Capital Payments - Non IT (Self Funded)	295	596	1,500	1,211	8,000	7,985	326	326	326	814	814	814	1,139	1,139	1,139	977	10,525
Capital Payments - IT(Self Funded)	100	0	100	100	5,140	3,000	587	587	587	652	652	652	1,044	1,044	1,044	976	8,025
Capital Payments - IT(Loan Funded)	0	0	(0)	0	6,831	6,800	0	0	0	0	0	0	0	0	0	0	(0)
<b>TOTAL</b>	<b>40,346</b>	<b>41,128</b>	<b>40,275</b>	<b>48,660</b>	<b>501,074</b>	<b>461,171</b>	<b>36,907</b>	<b>36,907</b>	<b>36,932</b>	<b>37,505</b>	<b>37,399</b>	<b>41,074</b>	<b>37,692</b>	<b>37,672</b>	<b>36,552</b>	<b>36,322</b>	<b>463,897</b>
<b>NET CASH INFLOW/(OUTFLOW)</b>	<b>980</b>	<b>(1,135)</b>	<b>1,699</b>	<b>9,183</b>	<b>7,824</b>	<b>(5,567)</b>	<b>715</b>	<b>(1,085)</b>	<b>(1,110)</b>	<b>(1,683)</b>	<b>(1,577)</b>	<b>(5,252)</b>	<b>2,630</b>	<b>(1,850)</b>	<b>(730)</b>	<b>(500)</b>	<b>440</b>
<b>CLOSING GBS CASH BALANCE</b>	<b>13,246</b>	<b>11,130</b>	<b>14,945</b>	<b>24,128</b>	<b>22,012</b>	<b>8,622</b>	<b>24,843</b>	<b>23,758</b>	<b>22,648</b>	<b>20,965</b>	<b>19,388</b>	<b>14,136</b>	<b>16,766</b>	<b>14,916</b>	<b>14,186</b>	<b>13,686</b>	<b>14,126</b>
Cheques not yet cleared	57	49	57	57	57	0	57	57	57	57	57	57	57	57	57	57	57
<b>Monthly Close</b>	<b>13,189</b>	<b>11,081</b>	<b>14,888</b>	<b>24,071</b>	<b>21,955</b>	<b>8,622</b>	<b>24,786</b>	<b>23,701</b>	<b>22,591</b>	<b>20,908</b>	<b>19,331</b>	<b>14,079</b>	<b>16,709</b>	<b>14,859</b>	<b>14,129</b>	<b>13,629</b>	<b>14,069</b>
Commercial Banks	35	28	28	28	35	215	35	35	35	35	35	35	35	35	35	35	35
Items in transit	(1,300)	(1,822)	(1,300)	(1,300)	(1,300)	(7)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)	(1,300)
<b>TOTAL CLOSING CASH BALANCE</b>	<b>11,924</b>	<b>9,287</b>	<b>13,616</b>	<b>22,799</b>	<b>20,690</b>	<b>8,830</b>	<b>23,521</b>	<b>22,436</b>	<b>21,326</b>	<b>19,643</b>	<b>18,066</b>	<b>12,814</b>	<b>15,444</b>	<b>13,594</b>	<b>12,864</b>	<b>12,364</b>	<b>12,804</b>

\*Given that majority of the contracts for 2016/2017 have not been agreed yet, the cash position beyond the financial year are based on very high level assumptions.

### Receipts

Although the disposal of Blenheim Terrace is planned for March 2016 the cash receipt (£6m) is not expected until April. The Woodfield Road car park receipt is also due in April 2016, with Marlborough Place following in October.

### Payments

In January '16 the Trust's 90+ days creditor performance was 1.07% (£0.78m) against target cap of 5% (£3.64m), compared to 1.01% last month.

The key credit balances that were more than 90 days overdue as at 31st of January were:

- NHS PROPERTY SERVICES LTD- £0.13 - Invoices are approved awaiting payment.
- LAMBERT SMITH HAMPTON- £0.11m - Invoices are approved awaiting payment.
- CANON (UK) LTD- £0.10m - Invoices are awaiting approval.

### Performance against Better Payment Practice Code

NHS – The Trust paid 42% (42% last month) of total transactions by number, and 25% (21% last month) of total transactions by value, within 30 days.

NON-NHS – The Trust paid 53% (52% last month) of total transactions by number, and 41% (41% last month) of total transactions by value, within 30 days.

**The Trust has a working capital facility of £15m with Lloyds bank which it can call upon to cover short term shortfalls in cash. In addition the Trust expects to drawn down in March 2016, £1.5m of a £6.8m loan from the DOH to fund clinical systems.**



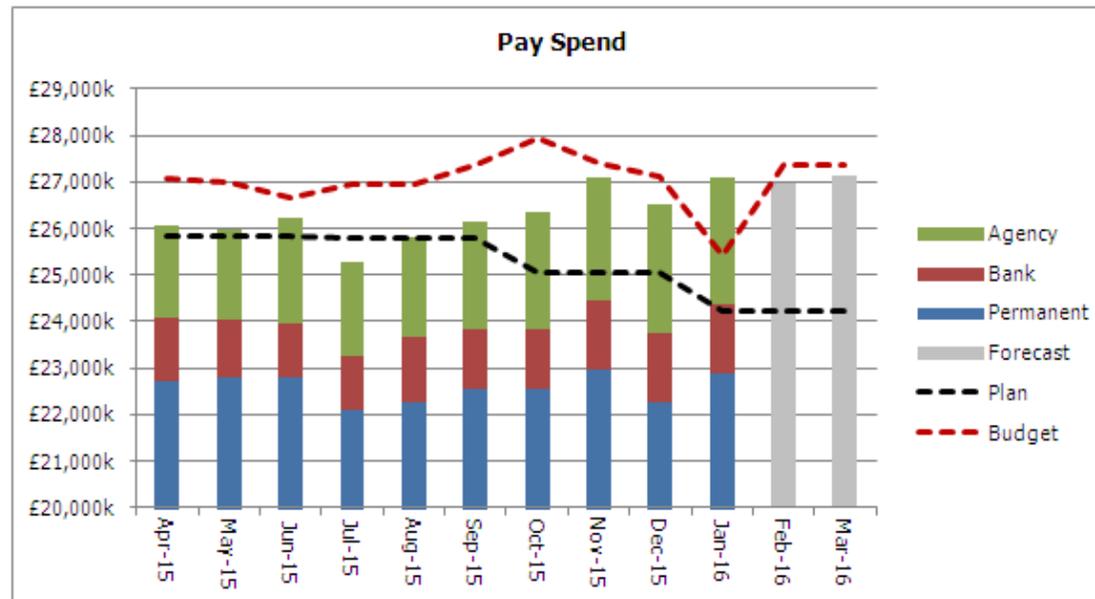
Summary

The Trust had cash of £9.3m at the end of January 2016 , a decrease of £0.746m from December 2015. The Trust continues to closely monitor cash to ensure current levels of liquidity are sustained. A further drawdown of £1.5m in March 2016 is intended on a £6.8m loan from the Department of Health.

	Actual For Month ending 30-Apr-15	Actual For Month ending 31-May-15	Actual For Month ending 30-Jun-15	Actual For Month ending 31-Jul-15	Actual For Month ending 31-Aug-15	Actual For Month ending 30-Sep-15	Actual For Month ending 31-Oct-15	Plan For Month ending 30-Nov-15	Actual For Month ending 30-Nov-15	Plan For Month ending 31-Dec-15	Actual For Month ending 31-Dec-15	Plan For Month ending 31-Jan-16	Actual For Month ending 31-Jan-16
<b>Cash Flow from Operating Activities</b>													
Surplus (Deficit) from Operations	(0.136)	(0.136)	(0.138)	1.660	0.103	(0.162)	0.648	0.417	(0.260)	0.416	(0.294)	1.374	(0.284)
Depreciation and amortisation, total	0.623	0.623	0.623	0.631	0.063	0.513	0.513	0.777	1.331	0.776	0.591	0.777	0.612
Impairment losses/(reversals)	-	-	-	-	1.532	(0.511)	(0.008)	-	-	-	0.268	-	-
Other operating non-cash (income)/ expenses	0.297	0.297	0.298	0.378	0.054	0.533	0.257	(0.620)	(0.773)	(0.620)	(0.712)	(0.611)	0.032
<b>Non-cash flows in operating surplus/(deficit), Total</b>	<b>0.920</b>	<b>0.920</b>	<b>0.920</b>	<b>1.010</b>	<b>1.650</b>	<b>0.534</b>	<b>0.761</b>	<b>0.157</b>	<b>0.558</b>	<b>0.156</b>	<b>0.146</b>	<b>0.166</b>	<b>0.644</b>
<b>Operating Cash flows before movements in working capital</b>	<b>0.784</b>	<b>0.784</b>	<b>0.782</b>	<b>2.670</b>	<b>1.752</b>	<b>0.372</b>	<b>1.409</b>	<b>0.574</b>	<b>0.299</b>	<b>0.572</b>	<b>(0.147)</b>	<b>1.540</b>	<b>0.360</b>
(Increase)/decrease in inventories	0.023	0.023	0.022	(0.088)	(0.014)	0.061	(0.198)	(0.008)	0.113	(0.009)	0.150	(0.008)	(0.211)
(Increase)/decrease in tax receivable	(0.366)	(0.366)	(0.365)	(0.623)	0.531	(0.321)	(0.588)	0.003	0.777	0.004	0.365	0.007	(1.287)
(Increase)/decrease in NHS Trade Receivables	(0.093)	(0.093)	(0.094)	1.783	(0.999)	3.382	4.083	0.267	1.321	0.266	(1.925)	0.333	(0.934)
(Increase)/decrease in Non NHS Trade Receivables	0.236	0.236	0.235	2.417	(0.434)	(0.227)	(2.509)	0.033	1.160	0.034	0.360	0.033	(0.357)
(Increase)/decrease in other receivables	0.049	0.049	0.050	(0.116)	0.141	0.051	0.078	0.002	0.185	0.001	(0.458)	0.002	0.362
(Increase)/decrease in accrued income	0.845	0.845	0.844	0.320	1.455	(0.776)	(0.576)	0.233	0.313	0.234	0.313	0.333	0.546
(Increase)/decrease in prepayments	0.197	0.197	0.197	(0.453)	0.092	(0.217)	0.726	0.033	(4.411)	0.034	(0.801)	0.033	0.168
Increase/(decrease) in Deferred Income (excl. Govt Grants.)	-	-	-	-	-	-	-	-	(1.009)	-	2.229	-	2.429
Increase/(decrease) in Deferred Income (Govt. Grants)	0.056	0.056	0.057	1.845	(0.181)	(0.801)	2.693	-	-	-	(2.693)	-	-
Increase/(decrease) in Current provisions	0.156	0.156	0.156	(0.139)	-	(0.032)	(0.126)	-	0.000	-	-	-	(0.028)
Increase/(decrease) in tax payable	(0.068)	(0.068)	(0.068)	(0.142)	(0.064)	0.118	(0.144)	-	0.185	-	(0.018)	-	(0.055)
Increase/(decrease) in Trade Payables	(1.379)	(1.379)	(1.380)	4.033	(3.692)	(0.104)	(0.248)	(0.300)	(2.927)	(0.300)	1.014	(0.300)	3.173
Increase/(decrease) in Other Payables	(2.369)	(2.369)	(2.369)	(2.101)	3.289	(1.428)	(0.933)	(0.567)	2.248	(0.566)	8.110	0.100	(2.328)
Increase/(decrease) in accruals	(0.151)	(0.151)	(0.152)	(2.630)	(1.815)	2.541	(1.995)	(0.260)	1.026	(0.259)	1.817	(0.743)	(1.951)
Increase/(decrease) in other Financial liabilities	0.180	0.180	0.179	(0.208)	(0.326)	(0.009)	(1.396)	-	(0.913)	-	0.153	-	0.004
Property - maintenance expenditure	(0.381)	(0.381)	(0.380)	(0.455)	(0.907)	(0.361)	(0.138)	(0.510)	(0.962)	(0.510)	(3.386)	(0.437)	2.132
Plant and equipment - Information Technology	-	-	-	-	-	-	-	(0.005)	-	(0.005)	-	-	-
Plant and equipment - Other	-	-	-	-	-	-	-	(0.123)	-	(0.122)	-	(0.109)	-
Property, plant and equipment - other expenditure	0.047	0.047	0.046	-	-	-	-	(0.363)	-	(0.364)	-	(0.287)	-
Purchase of investment property	-	-	-	-	-	-	-	-	-	-	-	-	-
Purchase of intangible assets	(0.506)	(0.506)	(0.507)	(1.119)	(0.506)	(1.014)	(0.883)	(1.048)	(0.226)	(1.049)	(0.325)	(0.983)	(2.909)
Increase/(decrease) in Capital Creditors	(0.115)	(0.115)	(0.115)	0.293	-	(0.437)	0.106	(0.012)	(1.063)	(0.011)	(1.455)	0.035	0.145
<b>Capital expenditure (cash basis), total</b>	<b>(0.955)</b>	<b>(0.955)</b>	<b>(0.955)</b>	<b>(1.281)</b>	<b>(1.412)</b>	<b>(1.813)</b>	<b>(0.915)</b>	<b>(2.061)</b>	<b>(2.252)</b>	<b>(2.060)</b>	<b>(5.166)</b>	<b>(1.781)</b>	<b>(0.632)</b>
Proceeds on disposal of property, plant and equipment	0.898	0.898	0.897	-	-	-	-	-	-	-	-	-	-
<b>Net cash inflow/(outflow) from investing activities, Total</b>	<b>(0.057)</b>	<b>(0.057)</b>	<b>(0.058)</b>	<b>(1.281)</b>	<b>(1.412)</b>	<b>(1.813)</b>	<b>(0.915)</b>	<b>(2.061)</b>	<b>(2.252)</b>	<b>(2.060)</b>	<b>(5.166)</b>	<b>(1.781)</b>	<b>(0.632)</b>
<b>Net cash inflow/(outflow) before financing</b>	<b>(1.936)</b>	<b>(1.936)</b>	<b>(1.940)</b>	<b>5.330</b>	<b>(1.799)</b>	<b>0.797</b>	<b>(0.629)</b>	<b>(2.051)</b>	<b>(3.884)</b>	<b>(2.049)</b>	<b>0.379</b>	<b>(0.451)</b>	<b>(0.751)</b>
<b>Cash Flows from Financing Activities</b>													
<b>Capital element of finance lease rental payments</b>													
<b>Other cash flows from financing activities</b>													
PDC Dividends paid	-	-	-	-	-	(4.094)	-	-	-	-	-	(1.367)	-
Drawdown of non-commercial loans	-	-	-	-	-	-	-	0.567	0.724	0.566	-	0.567	0.006
Increase/(decrease) in non-current payables	-	-	-	-	-	(0.008)	2.358	-	2.275	-	-	-	-
<b>Other cash flows from financing activities, total</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>(4.102)</b>	<b>2.358</b>	<b>0.567</b>	<b>2.999</b>	<b>0.566</b>	<b>0.000</b>	<b>(0.800)</b>	<b>0.006</b>
<b>Net cash inflow/(outflow) from financing activities, Total</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>(4.102)</b>	<b>2.358</b>	<b>0.567</b>	<b>2.999</b>	<b>0.566</b>	<b>0.000</b>	<b>(0.800)</b>	<b>0.006</b>
<b>Net increase/(decrease) in cash and cash equivalents</b>	<b>(1.936)</b>	<b>(1.936)</b>	<b>(1.940)</b>	<b>5.330</b>	<b>(1.799)</b>	<b>(3.305)</b>	<b>1.729</b>	<b>(1.484)</b>	<b>(0.885)</b>	<b>(1.483)</b>	<b>0.379</b>	<b>(1.251)</b>	<b>(0.746)</b>
<b>Opening Cash and Cash equivalents less bank overdraft</b>	<b>14.397</b>	<b>12.461</b>	<b>10.525</b>	<b>8.584</b>	<b>13.914</b>	<b>12.115</b>	<b>8.810</b>	<b>15.548</b>	<b>10.539</b>	<b>14.064</b>	<b>9.654</b>	<b>12.581</b>	<b>10.033</b>
<b>Closing Cash and Cash equivalents less bank overdraft</b>	<b>12.461</b>	<b>10.525</b>	<b>8.584</b>	<b>13.914</b>	<b>12.115</b>	<b>8.810</b>	<b>10.539</b>	<b>14.064</b>	<b>9.654</b>	<b>12.581</b>	<b>10.033</b>	<b>11.330</b>	<b>9.287</b>
<b>Check to Statement of Financial Position Variance</b>	<b>0.001</b>	<b>0.002</b>	<b>(0.001)</b>	<b>0.005</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>(0.000)</b>	<b>(0.000)</b>	<b>(0.000)</b>	<b>(0.000)</b>	<b>(0.001)</b>	<b>(0.000)</b>
<b>Net increase/(decrease) in cash</b>	<b>(1.936)</b>	<b>(1.936)</b>	<b>(1.940)</b>	<b>5.330</b>	<b>(1.799)</b>	<b>(3.305)</b>	<b>1.729</b>	<b>(1.484)</b>	<b>(0.885)</b>	<b>(1.483)</b>	<b>0.379</b>	<b>(1.251)</b>	<b>(0.746)</b>
<b>Opening cash less bank overdraft</b>	<b>14.397</b>	<b>12.461</b>	<b>10.525</b>	<b>8.584</b>	<b>13.914</b>	<b>12.115</b>	<b>8.810</b>	<b>15.548</b>	<b>10.539</b>	<b>14.064</b>	<b>9.654</b>	<b>12.581</b>	<b>10.033</b>
<b>Closing cash less bank overdraft</b>	<b>12.461</b>	<b>10.525</b>	<b>8.584</b>	<b>13.914</b>	<b>12.115</b>	<b>8.810</b>	<b>10.539</b>	<b>14.064</b>	<b>9.654</b>	<b>12.581</b>	<b>10.033</b>	<b>11.330</b>	<b>9.287</b>
<b>Check to Statement of Financial Position Variance</b>	<b>0.001</b>	<b>0.002</b>	<b>(0.001)</b>	<b>0.005</b>	<b>0.000</b>	<b>0.000</b>	<b>0.000</b>	<b>(0.000)</b>	<b>(0.000)</b>	<b>(0.000)</b>	<b>(0.000)</b>	<b>(0.001)</b>	<b>(0.000)</b>

## Pay Analysis – at Month 10

The chart below shows an analysis of the total pay spend of the Trust over this year, analysed between spend on bank staff, agency staff and permanent staff. The Plan line is as per our original submission to Monitor, whilst Budget is as per the current ledger (so includes new business but also any CIP which has not yet been actioned).



Total pay costs increased this month by £617k to £27.1m. Agency decreased by £13k, bank increased by £27k and permanent staff costs saw an increase £602k. Note that in December there was a one-off benefit of £430k so the adjusted increase for permanent staff is around £170k this month.

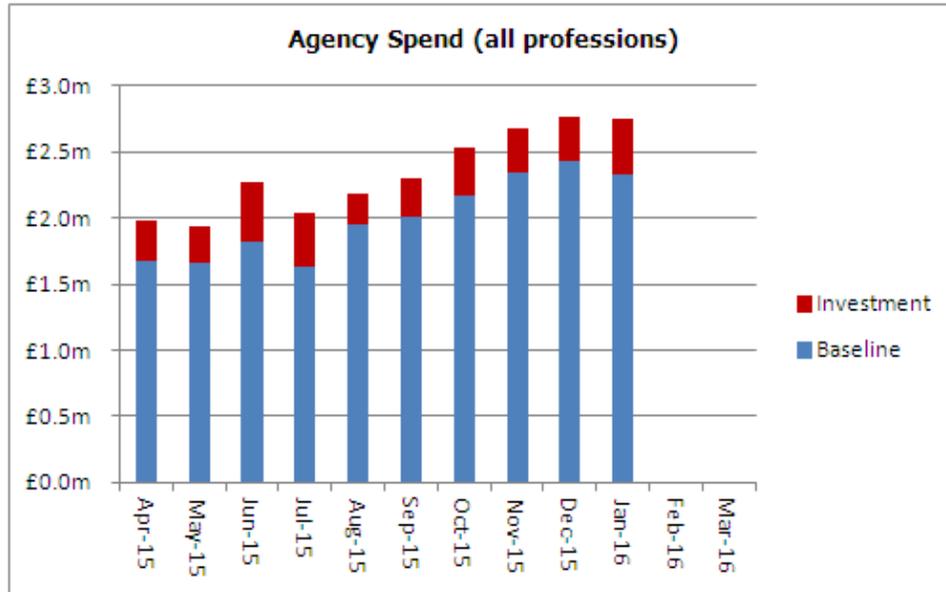
The plan the Trust submitted to Monitor assumed that after savings had been actioned the monthly pay cost in Q4 would be £24.2m. The Trust is currently running worse than this expectation. In general pay is under budget, although for January several backdated non-recurrent CIP plans were signed off.

The forecast monthly pay cost for Q4 is around £27m. Although this is worse than plan several new contracts have started this year which were not factored into the initial plan. Reductions in pay costs through CIP plans are either already in place (community redesign in NWL) or not expected to be realised (remaining CIP gap) so it is unlikely that pay will significantly reduce over the coming months.

We have seen a downward trend of WTE for permanent employees, from just over 5,800 in December last year, to below 5,600 now. This reduction has levelled off in recent months as new services are recruiting. Vacancy rates in some directorates are running as high as 28-31% (Brent and Addictions & Offender Care), although many budgeted posts are being held for CIP and redesign.

# Significant Variances – Agency Use – Month 10

12



### Total Agency

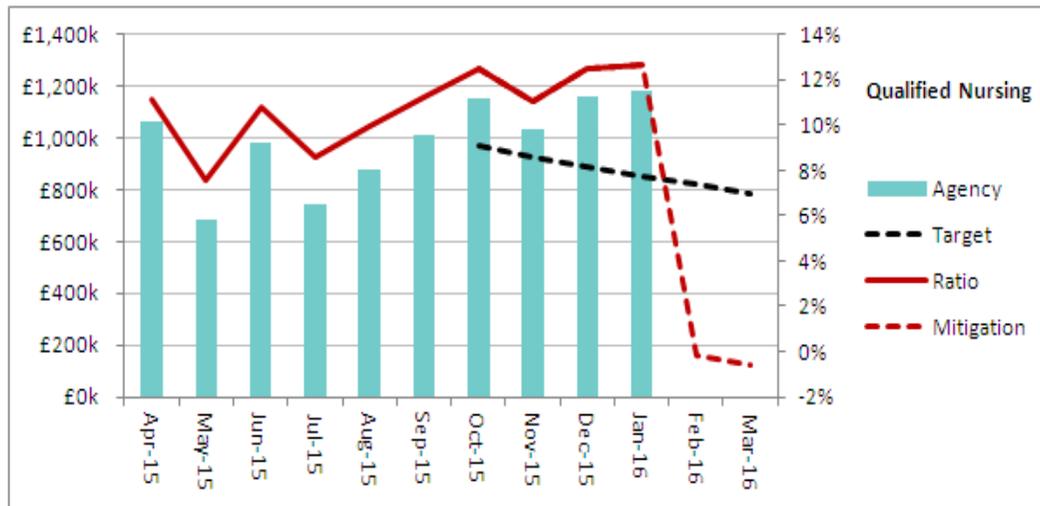
The first chart shows monthly agency spend since April 2015 with areas receiving additional investment separately identified.

Agency spend levelled off this month at £2.75m. Each month from July to December saw increases in total agency spend. Bank and permanent staff both saw increases in costs this month.

The increase in agency spend does not correlate with areas of additional budgeted investment. These fluctuate through the year but by a smaller margin than the increase in pre-existing services.

Monitor have introduced price caps on all agency staff for which we need to report exceptions. We also need to report use of non-framework nursing agencies.

The Trust is reporting around 900 shifts in breach of these rules each week (around 1/3 of shifts). For off-framework nursing agencies the most breaches are in Hillingdon Mental Health. Price cap breaches are mainly for Corporate Services and Addictions & Offender Care.



### Qualified Nursing Agency

Monitor have set targets on the percentage of agency spend for qualified nursing staff. CNWL needs to average an 8% ratio for October to March. This month the Trust averaged 12.70% against a target of 7.75%.

The Mitigation line shows how far proportional spend would need to reduce in order to meet the target. Given performance in recent months it is now impossible to recover and meet the overall target.

The target is being missed across all three clinical Divisions. More than half of clinical directorates are meeting the target but for those which miss the ratios are as high as 25% to 30%.

Targets have not been set for other staff groups.

## Debtors – Summary at Month 10

### Debt Summary:

- Total debt over term increased by £1.1m is £23.5m.
- In January 2016 the Trust's 90+ days debtors increased by £0.1m to £9.6m.
- The overall debt increase was largely due to £5.8m of debt moving in to 31-60 days overdue.
- Many of our largest local authority customers have moved to a new outsourced payment system which have been rejecting invoices. Accounts receivable staff are working with the outsourced local authority contacts to clear the backlog.
- Debts include:
  - *LB Hillingdon* £451k
  - *LB Camden* £303k
  - *LB Hammersmith & Fulham* £261k
  - *LB Hackney* £113k
  - *Westminster city council* £172k

### Debt Issues:

- £2.0m of outstanding debt is with Central London Community Healthcare NHS Foundation Trust (£1.0m over 90 days overdue).
- CLCH have put a hold on CNWL debt as we are in dispute over the IAPT contract in Kensington & Chelsea.

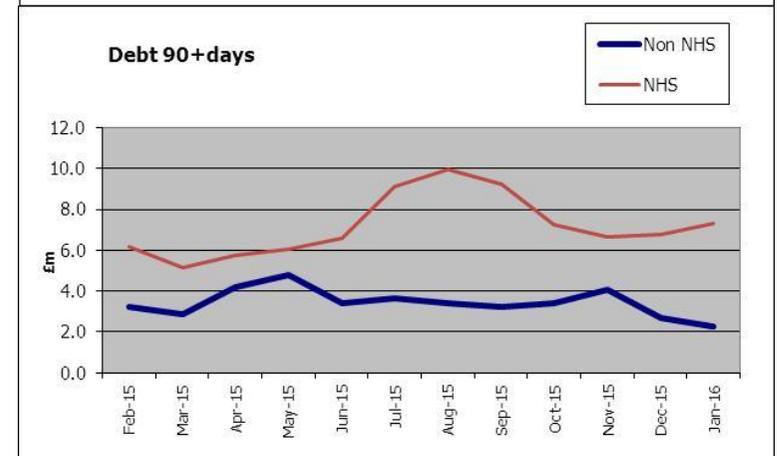
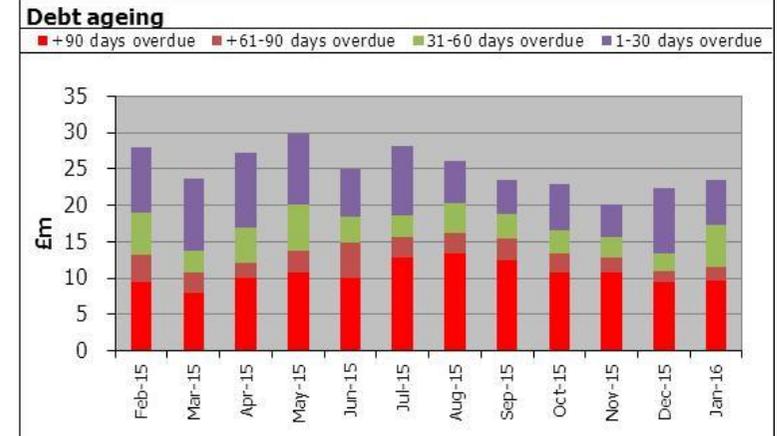
### Action Plan for Recovery of Debt:

The director of Shared Business Services (SBS) came to CNWL to discuss the issues with the service we are receiving.

SBS want to set up an improvement committee to look into a range of issues including debt recovery.

We are awaiting further details from SBS, we are asking for ownership of the debt issues, with penalties linked to performance for the SBS debt recovery team.

£m	2015-16 M06	2015-16 M07	2015-16 M08	2015-16 M09	2015-16 M10
Non NHS debt over term	8.3	9.9	9.5	9.2	7.7
<i>Of which &gt;90 days overdue</i>	3.2	3.4	4.1	2.7	2.3
NHS debt over term	15.2	13.0	10.6	13.2	15.8
<i>Of which &gt;90 days overdue</i>	9.2	7.3	6.7	6.8	7.3
<b>Total debt over term</b>	<b>23.5</b>	<b>23.0</b>	<b>20.1</b>	<b>22.4</b>	<b>23.5</b>
Total debt over term & invoices not due	29.4	29.6	26.7	28.1	29.6
<i>Of which &gt;90 days overdue</i>	<b>12.5</b>	<b>10.7</b>	<b>10.8</b>	<b>9.5</b>	<b>9.6</b>
Provision to cover this debt	3.2	3.3	3.2	3.2	3.2



## CIP and QIPP at Month 10

The table below shows the updated savings requirement compared to the amount identified or achieved at the end of January 2016.

Identified Plans include the total value this year of recurrent and non-recurrent schemes regardless of risk. Delivered plans to date are those which have been finalised and embedded with actioned budget reductions, and are compared to the year-to-date target.

The original target of £26.37M has been increased to cover a pressure of £1.4M from late contract reductions. There is another £1.7M of unidentified local savings relating to previous years in Milton Keynes services which will be resolved in setting the 2016-17 financial plan.

£000	Target	Identified Plans			Risk Adjusted		Plans to Date		
		Last month	This month	Shortfall	High Risk	Shortfall	Target	Delivered	Gap
Jameson	7,499	7,500	7,654	-155	543	388	5,831	5,511	319
Goodall	5,871	5,742	6,014	-143	143	0	4,873	4,430	444
Diggory	8,873	8,142	8,192	681	10	691	7,394	6,367	1,027
Corporate Services	4,944	3,862	3,690	1,254	45	1,299	4,120	1,126	2,994
	<b>27,186</b>	<b>25,245</b>	<b>25,549</b>	<b>1,637</b>	<b>741</b>	<b>2,378</b>	<b>22,218</b>	<b>17,434</b>	<b>4,784</b>

The Trust is currently £4.8m behind plan with its CIP and QIPP implementation. Savings were modelled based upon the schemes identified prior to the beginning of the year and expected to commence at the beginning of the year. Including un-actioned plans with year-to-date values we still have a gap of £1.6m to date which represents the expected position if all quality impact assessments and approvals are brought up to date.

There is currently a £1.6m gap in savings identified compared to requirements, this is a £304k improvement in comparison to the previous month. A further £741k is currently rated as high risk, which means overall it is expected CNWL will miss its savings target by £2.4m. This is a £100k deterioration on last months figure.

The value of identified plans has increased by £304k this month.

- Goodall shows an increase in plans of £272k compared to last month with additional non-recurrent income in Camden. Goodall have virtually met the current year's target and are developing 2016-17 plans. The Hillingdon Mental Health community redesign is flagged as high risk due to delays and is likely to slip into next financial year.
- Jameson have shown an improvement of £154k on last month's identified plans. This is from additional non-recurrent under-spends which won't have benefit in next financial year. Savings from the Brent, Westminster and K&C community redesign are all expected to be finalised next month.
- Diggory's identified plans decreased by £50k. Although the division has only achieved 92% of target there are minimal high-risk schemes remaining so we are not expecting any further slippage.
- Corporate Services have identified 75% of their target. However several plans of significant value are related to current under-spends rather than committed as budget reductions.

## SOCI Forecast Phasing

The table below shows the trend of SOCI lines to date, with projections to year end. Commentary is in the Forecast SOCI slide.

£m	Year to Date										Forecast	
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Activity income	34.26	34.40	34.24	35.10	35.50	34.26	35.12	34.74	34.62	35.35	35.61	36.31
Education & R&D	1.23	1.17	1.05	1.24	1.09	1.28	1.52	1.26	1.17	1.50	1.31	1.31
Other Income	1.83	1.63	1.85	1.89	1.75	1.73	1.88	0.87	1.30	2.07	1.41	1.41
<b>Total Income</b>	<b>37.32</b>	<b>37.20</b>	<b>37.14</b>	<b>38.23</b>	<b>38.34</b>	<b>37.27</b>	<b>38.52</b>	<b>36.87</b>	<b>37.10</b>	<b>38.92</b>	<b>38.34</b>	<b>39.03</b>
Pay Expenditure	(26.03)	(25.96)	(26.17)	(25.21)	(25.76)	(26.06)	(26.22)	(27.05)	(26.44)	(27.06)	(26.81)	(27.15)
Non-Pay Expenditure	(10.84)	(10.24)	(10.73)	(10.60)	(10.75)	(10.63)	(10.76)	(9.39)	(10.04)	(11.50)	(10.84)	(10.43)
<b>Total Trust Expenditure</b>	<b>(36.86)</b>	<b>(36.20)</b>	<b>(36.90)</b>	<b>(35.81)</b>	<b>(36.51)</b>	<b>(36.69)</b>	<b>(36.97)</b>	<b>(36.44)</b>	<b>(36.48)</b>	<b>(38.56)</b>	<b>(37.64)</b>	<b>(37.58)</b>
<b>EBITDA</b>	<b>0.45</b>	<b>0.99</b>	<b>0.24</b>	<b>2.41</b>	<b>1.83</b>	<b>0.59</b>	<b>1.54</b>	<b>0.42</b>	<b>0.62</b>	<b>0.36</b>	<b>0.70</b>	<b>1.45</b>
<b>EBITDA %</b>	<b>1.21%</b>	<b>2.67%</b>	<b>0.64%</b>	<b>6.31%</b>	<b>4.76%</b>	<b>1.57%</b>	<b>4.01%</b>	<b>1.15%</b>	<b>1.67%</b>	<b>0.93%</b>	<b>1.81%</b>	<b>3.72%</b>
Depreciation	(0.51)	(0.52)	(0.51)	(0.51)	(0.51)	(1.12)	(0.62)	(0.61)	(0.59)	(0.61)	(0.61)	(0.61)
Interest income	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividends, interest and other	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)	(0.68)
<b>Retained Surplus excl. Restructure &amp; Disposal</b>	<b>(0.74)</b>	<b>(0.20)</b>	<b>(0.95)</b>	<b>1.22</b>	<b>0.63</b>	<b>(1.21)</b>	<b>0.24</b>	<b>(0.87)</b>	<b>(0.65)</b>	<b>(0.93)</b>	<b>(0.60)</b>	<b>0.16</b>
Restructuring costs	(0.07)	(0.09)	(0.06)	(0.12)	(0.13)	(0.14)	(0.19)	(0.07)	(0.12)	(0.03)	(0.06)	(0.31)
Impairment	(0.26)	(0.08)	0.01	(0.12)	(1.08)	0.51	0.01	0.00	(0.27)	0.00	0.00	0.00
Profit on disposal	2.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.17	0.00
<b>Surplus</b>	<b>1.08</b>	<b>(0.37)</b>	<b>(1.00)</b>	<b>0.98</b>	<b>(0.58)</b>	<b>(0.84)</b>	<b>0.06</b>	<b>(0.94)</b>	<b>(1.03)</b>	<b>(0.96)</b>	<b>3.51</b>	<b>(0.14)</b>
<i>I&amp;E Surplus % (excl. Restructure &amp; Disposal)</i>	<i>-1.98%</i>	<i>-0.55%</i>	<i>-2.55%</i>	<i>3.20%</i>	<i>1.65%</i>	<i>-3.25%</i>	<i>0.63%</i>	<i>-2.36%</i>	<i>-1.75%</i>	<i>-2.39%</i>	<i>-1.55%</i>	<i>0.42%</i>

## BOD 29a/2016 This report is for publication

### Board of Directors

February 2016

### Report of the Business and Finance

#### Objective:

The Board is asked to note this report which highlights issues from the Committee which it is felt should be drawn to the Board's attention.

**The Board is asked to:** Note the report and discuss key issues raised.

#### Finance

We received the finance report for month 10 which indicates that we are still on target to meet our plan at year end. We discussed a number of variables both positive and negative. These include some additional income still being agreed in respect of 15/16 contracts as a positive but increased level of debt as a negative. Property disposals have assisted us in hitting the target this year and will also positively impact our liquidity levels in the coming year. We agreed to have an increased focus on debt recovery.

We also noted that it is imperative to bring down the levels of agency spend and noted that from a quality perspective the Quality and Performance Committee are also concerned. We noted that the executive are focusing on this issue and we have asked for a plan to be brought to our next meeting setting out the actions being taken and the timeframe within which these actions should have a demonstrable effect.

We recognise that the financial position next year will be even tighter and we will identify a number of key issues of which spend on pay will be one which we expect to have a month on month trajectory which we will closely monitor against.

#### Savings

We discussed the very difficult challenge to identify enough recurrent savings for next year but were pleased by how much services had managed to achieve to date this year.

## Contracting

We noted that we have yet to receive contract offers for 16/17 and while we understand that Monitor expect all contracts to be agreed by April 30th we note that this is a very tight timescale.

## Planning for 2016/17

We noted that the Plan will go to the Board in March and anticipate that the Board will want the Committee to review it at its meeting at the end of March before its submission to Monitor.

## Accountable Care Partnerships and Sustainability & Transformation Plans

We also revisited some of the discussion at the Board workshop and in particular looked at the changing health landscape with the development of the ACP and the progress on STPs. We noted that the engagement with and shape of STPs varies considerably from borough to borough. We also noted ongoing work in respect of new business opportunities and endorsed executive action in this respect

David Walker  
**Non-Executive Director**



**BOD 29b/2016**

**Draft**

**Final Operational Plan 2016/17  
For submission 11<sup>th</sup> April 2016**

**CNWL contact:**

**John Vaughan, Director of Strategy and Performance.**

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## CNWL Operational Plan for 2016/17 – Version for CNWL and Monitor only

This document completed by (and queries to be directed to):

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**Tel. no. for contact** 020 3214 5755  
**Date** 10<sup>th</sup> April 2016

In signing below, the Trust is confirming that:

- The Operational Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission; and
- The 'declarations' are true to the best of its knowledge.

**Approved on behalf of the Board of Directors by:**

**Name (Chair)** Professor Dorothy Griffiths

**Signature**

**Approved on behalf of the Board of Directors by:**

**Name (Chief Executive)** Claire Murdoch

**Signature**

**Approved on behalf of the Board of Directors by:**

**Name (Finance Director)** Trevor Shipman

**Signature**

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## Operational Plan 2016/17

This operational plan is the first year of five year Sustainability and Transformation Planning (STP). During this time, CNWL will play its role as a partner in delivering the aims set out in the 2015 Annual Spending Review - to deliver the Five Year Forward View (FYFV); to restore and maintain financial balance and; to deliver core access and quality standards for patients.

CNWL is a partner in developing place-based STPs in North West London, North Central London and Milton Keynes. Discussions have been commenced in NWL and NCL around the process and content of planning and a request has been sent to Milton Keynes for our involvement there. Significant progress has been made through round table discussions between commissioners and providers. This is set out Section 5.

CNWL's Vision, Values and associated Strategic Objectives, set out in Diagram 1 below, are designed to encompass our approach to achieving the FYFV and the principles of the NHS Mandate and Constitution. Our priorities, summarised in this document at Table 5, are checked against internal and external values.

### Diagram 1: CNWL vision, values and strategic objectives

#### Our vision

**Wellbeing for life:** We work in partnership with all who use our services to improve health and wellbeing. Together we look at ways of improving an individual's quality of life, through high quality healthcare and personal support.

#### Our values



COMPASSION

- **Compassion:** Our staff will be led by compassion and embody the values of care outlined in our Staff Charter.



RESPECT

- **Respect:** We will respect and value the diversity of our patients, service users and staff, to create a respectful and inclusive environment, which recognises the uniqueness of each individual.



EMPOWERMENT

- **Empowerment:** We will involve, inform and empower our patients, service users, carers and their families to take an active role in the management of their illness and adopt recovery principles. We will ensure our staff receive appropriate direction and support, to enable them to develop and grow.



PARTNERSHIP

- **Partnership:** We will work closely with our many partners to ensure that our combined efforts are focused on achieving the best possible outcomes for the people we serve.

#### Our strategic objectives

- **High quality care and best outcomes for patients**  
We will provide high quality care to people who use our services, and to their carers. These services will be safe, caring, effective, responsive and well-led when benchmarked nationally.
- **Operational stability**  
We will redesign our services to improve quality, efficiency and outcomes; with integrated care models that are easy to access, delivered in appropriate settings and in a way that meets patient and commissioner expectations; care that reduces need for unnecessary hospital admissions.
- **Financial sustainability**  
We will make the necessary savings and make sure all contracts are financially viable and comply with financial standards agreed by the Board to ensure organisational resilience and sustainability.

## 1. Activity, demand and capacity

CNWL has a wide range of services with variation in how activity is planned, reported and funded. This has set a challenge for us and our commissioners in terms of accurate demand and capacity planning. CNWL's organisational response to this for 2016/17 is set out at 1.1. In addition to organisational factors driving change in demand and capacity, there are demographic and societal changes which are discussed at 1.2

### 1.1 Organisational response:

#### 1.1.1 Managing demand and capacity looking forward:

CNWL has expressed an interest in taking part in the development programme of the Intensive Support Team (IST) methodology for both mental health and community services, which would be used for operational planning and for service redesign. This will help to overcome a situation where different approaches to analysing funding and activity have led to different conclusions on gap and action required. While it is not anticipated that contracts for 2016/17 will be based on a fully integrated approach to planning demand and capacity, ongoing discussions externally and staff development internally are designed to form the basis of agreed planning within the STP.

#### 1.1.2 Managing inpatient capacity:

Plans to reduce inpatient capacity in community and mental health have been put on hold by commissioners as part of the dialogue around redesign. Where additional beds are needed, capacity is increased through purchase of provision in other NHS trusts or in the private sector.

#### 1.1.3 Benchmarking:

- CNWL is part of the national mental health benchmarking club, which supports understanding existing practice in the context of other trusts and learning from that. Key intelligence from this includes:
  - Inpatients – CNWL started 2015/16 as one of the four highest occupancy rates of inpatient beds in the country, at 94% and rising in line with the national trend. This led to unacceptable pressures in the last quarter of 2014/15. The immediate issue for CNWL in February 2015 has been addressed but the issue of pressure on beds is ongoing. Spikes in demand are anticipated using past activity and monitored for forward planning.
  - CNWL has higher staff vacancy rates and turnover than the national average – although the lowest in London. However, this impacts on cost and quality and is being addressed through a programme to address agency use and improved bank use (section 3.2).

#### 1.1.4 Development of tariff:

- The continuing use of block contracts in most mental health and community services means that payment for additional use beyond capacity has historically been subject to debate.
- Further to Monitor's response to the consultation, the timescale for move to tariff is now clear, to be by 2017/18.
- This is further supported by Taskforce determination that use of activity based on block is no longer acceptable.
- CNWL is moving to a shadow mental health payment system based on caseload by super cluster in 2016-17, and continues to work with Monitor on non-acute tariff development.
- CNWL will be undertaking a programme to address variation in reference costs during 2016/17.

### 1.1.5 Productivity:

- This is a workstream within Service Redesign, and is monitored through a range of indicators e.g. sickness, turnover and agency costs. Productivity has been analysed and capacity rebased for community mental health teams (CMHTs) as part of the re-design process. It is hoped that IST methodology will support future work.
  - During 2016/17 the **review by Lord Carter** will be finalised and will provide a framework around management costs and estates usage – with a focus on variation. This is further discussed in the Finance section (4).
  - Development of **STPs and ACOs** will further support productivity and efficiency through sharing of management costs. This is further discussed in the STP section (5)

### 1.1.6 Meeting national indicators of quality services:

- As well as existing relevant indicator, there are **two new mental health indicators** for 2016/17. Work is underway to ensure that there is capacity to address these measures. This involves the appropriate mix of additional funding and redesign which is part of contract negotiations and discussions with commissioners:
  - 50% of people with first episode psychosis seen in two weeks. There has been analysis of **Early Intervention Teams** to assess capacity to meet the waiting times targets and discussions are underway with commissioners around resources to meet the additional staff that will be required to meet this indicator.
  - 75% of people with relevant conditions to **IAPT** seen in 6 weeks; 95% in 18 weeks. CNWL and our commissioners established an agreed level of resource and model of service delivery meet this target, which is on track for delivery.

## 1.2 External drivers for change in demand and capacity:

### 1.2.1 Policy and commissioning intentions:

The policy environment is framed by the FYFV. However, there is ongoing development, for example in relation to mental health strategy. This is further discussed at Section 5 and summarised at Appendix 3

### 1.2.2 Demographics:

CNWL reviews population change and use of service to anticipate service demand each year. This informs contracting discussions with commissioners. Assumptions are shared with commissioners through consultation each time our strategic plan is refreshed and are discussed through care quality governance in each locality. Information on demand planning is publicly available on our website through the published plans<sup>1</sup>.

- a) **Population:** As set out in previous plans, population across CNWL is projected to rise by 8% between 2014/15 to 2020/21. This is slightly higher than the London average at 7% over that period. Distribution of growth across CNWL is, however, very varied both for whole populations and between groups. Hillingdon and Milton Keynes are CCGs and local authorities with significant financial challenge, and yet will grow by 10% in the analysed years. In inner London, Kensington and Chelsea remains the borough with least growth overall, 2%, as in previous years.
- b) **Age:** In Milton Keynes, over 34% of the population is projected to be over 65 years of age by 2021, followed by Kensington and Chelsea at 23%. This older population will require increasing levels of resource and integrated services. The child population will grow by 15%

<sup>1</sup> **Strategic Plan 2014/15-2018/19.** [http://www.cnwl.nhs.uk/wp-content/uploads/CNWL\\_Strategic\\_Plan\\_2014-19.pdf](http://www.cnwl.nhs.uk/wp-content/uploads/CNWL_Strategic_Plan_2014-19.pdf)

in Hillingdon, and by 13% in Harrow and Milton Keynes. Again, there are specific needs associated with young people, including the prevention agenda, which is highlighted in the FYFV as essential to the sustainability of the NHS and the national financial position.

- c) **Deprivation and impact on health:** While deprivation with associated impact on children and longer-term health is much worse than the English average in the boroughs of Westminster, Kensington & Chelsea, Camden, and Brent, these boroughs have lower levels of smoking and associated disease in relation to national and North West London figures<sup>2</sup>. Deprivation in the outer London boroughs, particularly Harrow, is low, but morbidity associated with diabetes and cardiovascular disease is considerably higher than average for London. Milton Keynes shows a mixed picture – less deprivation and long term-unemployment, but more violent crime and homelessness.

### 1.2.3 Pressure on Acute Services:

Pressure on A&E and beds in acute hospitals, particularly in North West London, is felt elsewhere in the system. Difficulties in managing demand faced by acute trusts which are addressing critical levels of demand are passed on to mental and community health providers. This relates to all services, including children's services. Specifically in relation to children, the closure of Ealing Hospital A&E to CAMHS is pushing activity into Chelsea and Westminster and St Mary's A&E Liaison Psychiatry services, run by CNWL. The Trust is seeking more support from commissioners to reflect demand. Where a patient requires a bed that cannot be provided by CNWL but is within contract, other NHS or private providers are used.

## 2. Quality Planning:

CNWL started this operational year in receipt of the findings of a CQC inspection in February 2015. This provided impartial data on where the organisation needed to focus quality improvement.

**2.1 Quality Improvement – to meet safe, high quality care and achieve outstanding from the CQC:** The CQC carried out a comprehensive inspection of the Trust in February 2015. The CQC rated the Trust overall as 'requiring improvement' with 24 areas being deemed non-compliant. Across the five CQC domains, the Trust was rated overall as outstanding for 'caring', and good for 'effective' and 'well-led'. Sexual health services were rated as "outstanding", and district nursing, health visiting, podiatry, end of life care, community health inpatient and dentistry were rated "good".

Our 24 non-compliant areas (our "Must-Dos") were predominantly around processes and escalation protocols to manage demand for mental health inpatient services in London. In addition, environmental adjustments were recommended to improve privacy, dignity and security and areas of better record keeping to evidence appropriate clinical management. An action plan to address the "Must-Do" compliance areas was agreed with the CQC and delivery is overseen by the weekly CQC Project Group. At January 2016 the Trust declared full compliance against the 24 Must-Do compliance actions. Monitoring continues into 2016/17, overseen by the Divisional Quality Boards.

**2.2 CNWL Quality Inspection:** In November 2015, CNWL undertook its own Trust wide quality inspection. All services were inspected by staff, commissioners, service users, carers, HealthWatch and other interested parties. The inspection tool was based on Key Lines of Enquiry (KLOEs) the five CQC domains of safe, effective, caring, responsive and well led. Bringing together CQC findings and those of the Quality Inspection, four key themes have emerged to be addressed in 2016/17 and reflected in our plan:

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<sup>2</sup> **Public Health overview – Health Indicators: 2015.** Summarised at **Appendix 1**

- **Staffing** - the difference in quality of experience for patients who are looked after by permanent rather than agency staff was evident from the review. There has been a focus on agency reduction in 2015/16. This will continue in 2016/17 through a series of actions, discussed further at section 3.2 below.
- **Leadership** – related to the above, wards with stable staffing and good leadership show much better quality in all aspects. It is essential to achievement of the full impact of accountable clinicians and named nurses – in inpatient and community settings, in line with guidance from Academy of Medical Royal Colleges<sup>3</sup>.
- **Care Planning** - this is the overarching quality priority for 2015/16. However, there is a lack of consistency of how care planning is done. On the workplan for 2016/17 is a standard care planning process, which will be embedded in SystemOne as that is rolled out.
- **Physical Environment** – issues here are both about the quality of some localities – of which CNWL is aware – but also the need to ensure that spaces are clear and well kept. The environment has a direct impact on the experience of patients, and staff happiness at work. During 2015/16, workshops have been held with clinical teams to identify which parts of the estate could be better used – or resources from them redeployed.

### 2.3 CNWL's Quality Priorities 2016/17

CNWL has an annual consultation process involving service users, carers, commissioners, Health Watch and other stakeholders to identify our Quality Priorities for the forthcoming year. This process is underway and will conclude in May 2016.

CNWL's Quality Priorities for 2015/16 encompass three indicators under the overarching aim of **Effective Care and Treatment Planning**. These include the improvement and monitoring of both patient and carer involvement in care and treatment planning, and an outcome measure of patients reporting that their care or treatment help them achieve what mattered to them. These priorities are aligned to the NHS Constitution and CNWL's vision and values as described toward the start of this document. They are also key to implementation of strategies for patient and carer engagement – as partners in delivery of care. These Quality Priorities are supplemented with a number of other key indicators including further survey and clinical audit items. Progress against our action plans are tested once a quarter and where necessary mitigation plans are put in place by the team or service. This is overseen by the Quality and Performance Committee.

### 2.4 CNWL's Sign up to Safety Plan:

As part of the sign up to safety initiative, the Trust has identified the following areas where we will be undertaking specific work to support harm reduction during 2016/17:

- Pressure ulcers
- Medicines management
- Violence reduction
- Falls
- Suicide and self-harm

The Trust has engaged with both the Imperial and Thames Valley Academic Health Science Networks and will be working in partnership with these agencies to support delivery throughout 2016/17.

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<sup>3</sup> AMRC 2014. Guidance for Taking Responsibility: accountable clinicians and informed patients.  
<http://www.aomrc.org.uk/doc /9675-taking-responsibility>

Work is underway to support a range of projects which will utilise quality improvement methodology.

### **2.5 Implementing 7 Day Services:**

CNWL delivers 7 days services and these will be further developed during 2016/17:

- There is 7day medical cover week and specialty doctors attend all admissions at the weekends as well as in the week.
- During 2016/17 there will be further ongoing negotiation with consultants around their role to provide support to mental health community patients. An evening and Saturday service in Brent was not found to be cost effective but will be re-piloted – potentially in a different locality – in 2016/17
- The Single Point of Access – is available 24/7/365 as a phone and booking line. It is complemented by a Home Treatment and Rapid Response Team (HTRRT) in North West London. Development of CNWL's crisis response is a key part of our STPs in North West London, North Central London and Milton Keynes
- CNWL provides 24/7 liaison psychiatry in hospitals. Liaison nursing is available in ED with access to medical support
- The closure of A&E facilities in North West London has pushed demand for CAMHS liaison psychiatry into the remaining hospitals, and additional investment is being negotiated for specialised CAMHS liaison nursing posts. The aim is for this to be further developed in 2016/17

### **2.6 QIA process**

During 2016/17, all savings and redesign plans will again be subject to CNWL's established Quality Impact Assessment process (QIA). Coordination of QIA sign-off has been strengthened by the programme management office (PMO) for 2016/17. All savings or redesign must be agreed at each level of the organisation for effectiveness, safety, risk to quality and clinical mitigation of impact – subject to a monitoring process overseen by the PMO. QIAs must be signed off by the Divisional Medical and Nursing Directors, before they are escalated to the Executive for consideration and Board approval, including sign off by the Medical Director and Director of Nursing and Quality. The criteria are set out at **Appendix 2**.

### **2.7 Delivery of priorities identified by the Mental Health Taskforce**

The taskforce has set out plans which are necessary to care quality and to effective use of resource. A focus on young people and on quick access will form part of CNWL's prevention strategy with partners. Similarly, using and adapting new care approaches which have been found to be beneficial – such as Open Dialogue which CNWL has used in our HTRRT models. Through such means we aim to reduce unnecessary use of medication which has individual physical benefits, as well as system-wide efficiency gains.

### **2.8 Triangulation of and risk management of quality and performance:**

CNWL has developed scorecards and an integrated dashboard which brings together information on quality performance (external and internal standards), finance, workforce and safety as measured through a suite of indicators.

These are available to a range of stakeholders – commissioners, corporate services and front-line staff. They provide information from service level to a corporate overview. The Trust ICT strategy, the national 20/20 strategy and the completion of the Trust's move to SystmOne for core services in 2016/17 will further enhance the range and use of scorecards.

Key indicators are set out at **Table 1** on next page

**Table 1: Dashboard Standards:**

<b>Finance</b>	<ul style="list-style-type: none"> <li>Budget</li> <li>CIPs</li> <li>Forecast</li> </ul>
<b>Performance</b>	<ul style="list-style-type: none"> <li>Monitor indicators</li> <li>Internal Indicators</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>Vacancy</li> <li>Sickness</li> <li>Training</li> </ul>
<b>Quality and Safety</b>	<ul style="list-style-type: none"> <li>Quality Account                             <ul style="list-style-type: none"> <li>Patients involved as much as they want</li> <li>Patients feel their care and treatment helped meet goals</li> <li>Carers feel as involved as they want to be</li> </ul> </li> <li>Quality Indicators to cover:                             <ul style="list-style-type: none"> <li>Dignity and respect</li> <li>FFT</li> <li>Involvement in planning care</li> <li>Crisis access</li> <li>Physical care</li> <li>Crisis care</li> <li>Risk assessment</li> <li>Care planning</li> <li>Identification of a carer</li> </ul> </li> <li>Safety                             <ul style="list-style-type: none"> <li>Restraints</li> <li>Incidents</li> <li>Assaults</li> <li>Absconson</li> <li>Complaints</li> <li>Compliments</li> </ul> </li> </ul>

### 3. Workforce Planning:

CNWL's aim in 2016/17 is to develop an organisation where people deliver excellence and feel involved, inspired, appreciated, fulfilled and healthier at work. We must simultaneously meet the recommendations of reviews, such as that of Lord Carter, to reduce wastage such as unnecessary use of agency staff, and increase productivity in the NHS. These aims are compatible:

- Effective leadership is essential to managing quality of care and wellbeing of staff, including impact on recruitment and use of agency. It was identified as a priority in Lord Carter's review and in CNWL's quality inspection
- Agency use and its reduction is part of the workforce strategy but is also an action plan for immediate action which started in 2015/16 and will continue into 2016/17
- Our workforce planning framework is supported and informed by education, leadership, engagement and health and wellbeing strategies
- CNWL's workforce strategy is internally influenced by a number of factors including Service Redesign (4.3.1.c) and externally by growing partnership opportunities such as accountable care partnerships (section 5)
- A review of frontline vs back office staff is being undertaken and benchmarked with other trusts and organisations to identify where there are potential savings.

#### 3.1 Clinical engagement and governance of workforce planning:

Clinicians are represented in workforce planning centrally and through Divisions:

- A central education team engages with and consults with Divisions on workforce development and plans: an annual learning needs analysis takes place in every division
- Workforce plans are developed and agreed with service and divisional managers, clinicians and directors and are subject to quality impact assessment processes (QIA)

- Divisional and Borough management teams monitor vacancy rates closely and the divisional recruitment project which includes a programme to reduce agency use
- A project led by the Director of Nursing in 2015 reviewed capacity and leadership amongst Allied Health Professional (AHP) where high levels of turnover and agency are apparent in some areas. This is a quality issue as well as one of efficiency. Any restructure as a result of the review will take place in 2016/17
- During 2015/16, CNWL integrated medical, clinical and non-clinical education teams with a view to strengthening the approach to inter-professional education both within the organisation and with university partners.

An important part of the workforce strategy is to meet the needs of emerging **new models of care** and **accountable care partnerships**. These require local and central leadership for development. A number also require staff – currently these are existing roles such as Band 7 nurses – a pool that is becoming increasingly difficult to maintain. In the next year, we expect to be further developing ACPs, with consideration of new roles or redesign of functions so that we can recruit in sufficient numbers. Additional FYFV funding has not at this time been provided for these roles.

### **3.2 Managing Agency use:**

CNWL has short and longer term plans to reduce agency use as a priority for the Trust. CNWL has a recruitment challenge, in common with other London Trusts, and this is particularly acute in some settings such as offender health care.

CNWL's Director of Nursing is leading a programme of review and management of agency and to support the Monitor requirement to meet the cap on agency use, while maintaining safe staffing levels – and this will continue throughout 2016/17. There is a triangulation process to constantly monitor vacancies, agency and service change..

There are a number of workstreams flowing from the agency reduction programme:

#### **a) A short term programme of agency management:**

- All agency use is subject to a twice weekly meeting – to examine, challenge and reduce off-framework and use over the cap; and to understand drivers of agency use (close observations, recruitment and retention issues; hard to fill posts, additional funding for short-term programmes, efficiency issues re use of e-roster/bank etc)

#### **b) Recruitment and Retention Plan:** This was started in nursing for rollout to all professions in 2016/17. Aims and actions include -

- Increase use of bank staff – payment has been brought in line with competitors in NWL with roll out plan. New rates introduced from December 2015 with new model operational from April 2016
- Incentivise bands 5 and 6 to attract the best newly qualified staff – golden hellos and retention payments, accommodation, rotational programmes
- Develop a clear apprentice pathway for bands 3 and 4 during 2016/17
- Recruitment plans and lead responsibilities established in each Division from December 2015
- Review of recruitment process from start to finish and redesign team - review of weekly TRAC reports from December 2015
- Review of staff engagement/staff health and wellbeing strategy and leavers data – from March 2016

**c) E-rostering:**

This is now in use across the organisation to manage resource and the application of agency rules to achieve appropriate staffing levels.

**d) Training and development:**

CNWL has an extensive internal training and development programme of mandatory and additional courses. For 2016/17, CNWL has been successful in obtaining funding from Health Education North West London to support education innovation projects and transformation programmes through interprofessional training. These include a joint programme by the CNWL Medical Education Team and the Recovery College to pilot an Outreach Peer Support Worker and tutor role in a primary care setting. This is to influence health behaviours and outcomes of GP 'frequent attenders' through a programme of Learning for Healthy Living. Another is non-medical prescribing, specifically looking at the role of Physicians' Assistants.

**3.3 Triangulation and risk management of staffing:**

Quality and Safety metrics are triangulated with workforce indicators to identify areas of risk – see Table 1.

**4. Financial Planning**

*This section will be amended with updated financial assumptions to be discussed on the 31st of March at the Business and Finance Committee, before agreement of the final Plan for submission*

**4.1 Forecast and Modelling:**

Assumptions used to forecast and model the 2016/17 Financial Plan

**Income assumptions:**

- I 1 NHS income is inflated by 1.1% (based on expenditure inflation of 3.1% and efficiency requirement of 2%, as set out in the Planning Guidance).
- I 2 Local Authority income deflated at 3.9 % (based on expenditure inflation of 3.1% and efficiency requirement of 7%, estimated by the Finance Team)
- I 3 Services which have inflator or deflator as a contractual clause are inflated or deflated appropriately (e.g. offender care and addictions services)
- I 4 Income will continue at the current levels unless Commissioners have given a clear indication that services will be subject to procurement processes
- I 5 No impact from QIPP programmes of individual health systems is assumed at this stage
- I 6 CQUIN (Commissioning for Quality and Innovation) non-recurrent income reflected in plan will be received in full and will be used to fund recurring cost of operational services
- I 7 Income generation is achieved in full for both existing and planned schemes
- I 8 No adverse impact from outcome based payments for adult and older people's mental health services, or, increase/decrease in cost and volume contracts
- I 9 No growth has been assumed at this stage
- I 10 The £3.1m non-recurrent funding from NW London CCGs is rolled over in 16/17 baseline. Additionally, the £0.6m Early Intervention Funding for 15/16 is added into the 16/17 contract for NW London CCGs. Additional full year funding to be added for 16/17
- I 11 2015/16 recurrent income is forecast to year-end and adjustments made to reflect contracts lost
- I 12 £ 1.9 million is included as the full year value of investment in NWL for Urgent

Care services

- I 13 There are no contract penalties imposed
- I 14 Milton Keynes CCG add to the contract growth (£1.5m) without removing areas of non-recurrent funding that have been given non-recurrently for a number of years. (£0.5m)
- I 15 Any redundancy costs arising from the closure of Holloway prison, in respect of health staff are borne by NHSE or MOJ. The Trust is working to minimise the impact of the MoJ's decision to close Holloway
- I 16 All commissioners abide by the nationally agreed tariff rules
- I 17 NHSE fully fund the staffing establishments at HMP Woodhill that are required to provide safe staffing
- I 18 Equity of Esteem is applied

**Expenditure assumptions:**

- E 1 An average expenditure inflation of 3.1% is assumed for 2016/17 as set out in Monitor Guidance. Local cost pressures such as incremental drift is assumed to be met by realigning budgets
- E 2 All direct expenditure associated with the loss of the Prisons and Triborough Addictions Contracts are assumed to be saved. No redundancies are assumed at this stage
- E 3 The Trust CIP programme is delivered in full across the planning period through recurrent and non-recurrent schemes
- E 4 No financial impact from workforce strategy / recruitment and retention issues or difficulties
- E 5 Transformation Project Team costs of approximately £ 1.0 million is expected to continue.
- E 6 All redundancies arising from the savings initiatives will be built in as part of the business case for project – there is no separate redundancy reserve established
- E 7 Milton Keynes CCG service expenditure overrun of £ 2.0 million is **not** carried forward in the expenditure base to 2016/17
- E 8 The cost component of services covered by the NWL non-recurrent income of £ 3.1 million (assumption I 10) is carried forward in the expenditure base to 2016/17
- E 9 In addition to the above expenditure overspend, a further expenditure overspend of £ 5.0 million is carried forward to 2016/17. These relate to the undelivered current year CIP schemes. However, this has been matched off by a CIP carried forward target and it assumed that within the next few months schemes will be identified to meet this target
- E 10 No quantifiable financial impact from population/demand changes is modelled financially
- E 11 Loss of contribution from the Triborough and Prison contract cessations are modelled in at £ 3.2 million. It is anticipated that the loss will be reduced once directly attributable indirect and back-office costs associated with the loss of these tenders are identified as potential savings.
- E 12 Cost pressure relating to PropCo will be fully funded (including where Commissioning responsibility has transferred to Local Authorities e.g. School Nursing, Health Visiting etc).

**Other Revenue and Expenditure:**

- V 1 Property sales cover the requirement to generate cash for capital repayment of the £ 6.8 million loan drawn down this year
- V 2 The structural deficit of £ 7.4 million is carried forward and no exceptional item (surpluses from property disposals) are assumed to offset this deficit as in previous
- V 3 years

The Trust is planning a deficit of £ 3.8 million

**Balance Sheet and Capex Plans:**

- X 1 All capital allocations from internally generated sources are inadequate to finance the Capex programme for 2016/17. It is assumed that non-CRS properties will be sold (Marlborough House and the Woodfield Road Car Park) and External Borrowing is required/or the Capex is paired.
- X 4 Fixed Assets will be at their revalued costs as at 01 April 2016.

**Cash Plans:**

- C1 Main contract payments will be received on time
- C2 Debtor and Creditor days are assumed to be at the same levels
- C3 Any potential bad debts can be contained within the provisions made
- C4 As a result of the loss of the Prisons and Addictions services tenders transfer to a new provider is assumed as April 2016 and any liability relating to the Local Government Pension Scheme will be limited to the provision as at 31 March 2016

**4.2 Forecast Income and Expenditure:**

Income modelling assumptions are derived from Planning Guidance, finance department estimates, contract negotiations and contractual clauses are set in the table 2 below:

**Table 2 – Forecast Opening Income 2016/17**

	Closing Income 31.03.16 £ m's	Income Inflation / Deflation £ m's	Growth, Investments/ Disinvestments £ m's	CQUIN £ m's	QUIPP £ m's	Opening Income 01.04.16 £ m's
NW London MH	200.6	2.3	2.0	4.0	-	209
London Community HS	65.8	0.9	(0.3)	1.4	-	67.9
Additions and Offender Care Services	17.4	(0.0)	(6.2)	0.0	-	11.2
Prison Services	28.6	0.0	(10.3)	0.3	-	18.6
Sexual Health Services	52.3	(0.7)	-	0.3	-	51.8
Services commissioned by MK CCG	52.6	0.4	1.3	0.9	-	55.3
NHS England	11.0	0.2	-	0.2	-	11.4
Revenue Generation	2.4		-			2.4
<b>Total</b>	<b>430.6</b>	<b>3.2</b>	<b>(13.5)</b>	<b>7.2</b>	<b>-</b>	<b>427.6</b>

**4.3 Expenditure Plan:**

- The Trust's budget setting process has identified a number of local cost pressures that are unable to be accommodated within existing resources. These total £ 5.1 million and predominantly relate to services provided in Milton Keynes and North West London mental health services. No other local cost pressures are modelled for 2016/17.
- Built-in to this financial plan is an unachieved CIPs of £ 5.0 million for all divisions from 2015/16.

- A summary of forecast expenditure for the 2016/17 financial year is summarised in Table 3 below by significant contract
- In overall terms therefore, the Trust has a total gross initial forecast expenditure plan for 2016/17 of £ 455.7 million and is set out below in Table 3:

**Table 3– 2016/17 Forecast Expenditure by Contract pre CIP**

	Closing Expen. 31.03.16 ms	Cost Inflation £ ms	Growth, Investments / Dis Investments £ ms	CQUIN £ ms	QUIP P £ ms	Opening Expen 01.04.16 £ ms
NW London MH	207.0	8.0	1.7	-		216.8
London Community HS	76.7	2.8	-	-		79.5
Additions and Offender Care Services	17.9	0.5	(4.4)	-		14.0
Prison Services	28.6	0.7	(9.0)	-		20.3
Sexual Health Services	48.8	1.8	-	-		50.6
Services commissioned by MK CCG	60.9	2.3	1.3	-		64.5
NHS England	10.9	0.4	-	-		11.3
Recharges, Structural Deficit, Unmet CIP and other n/r	(20.9)					(3.3)
<b>Total</b>	<b>429.9</b>	<b>16.5</b>	<b>(10.4)</b>	-	-	<b>453.7</b>

#### 4.3 Potential Planning Shortfall:

**Planning Shortfall for 2016/17:** At this stage of the process, it will be evident that the Trust's forecast expenditure of £ 453.79 million exceeds the forecast income of £427.6 million by £ 26.1 million for 2016/17. The total planning shortfall facing the Trust in 2016/17 is £26.1 million.

##### 4.3.1 Bridging the Financial Shortfall

###### a) Efficiencies:

Although the Trust has a good track record of delivering CIPs, over the past two years it has been increasing difficult to deliver planned efficiencies. This also has the impact of requiring 'transformational' schemes to deliver an increasing proportion of our CIP programme, and this is particularly the case for our 2016/17 plans.

###### b) Agency spend:

The narrative on CNWL's use of agency is set out in the Workforce section at 3.

**c) Service Redesign:**

Service Redesign is a three year programme to drive efficiency and productivity across the Trust, to transform services, improve quality and efficiency and improve patient outcomes. It is led by Dr Alex Lewis, Medical Director.

**ci) Achievements of Service Redesign in year 1 (2015/16) include implementation of:**

- 24/7/365 North West London (NWL) Adult Mental Health Single Point of Access (SPA). 3 November 2015
- 24/7/365 NWL Home Treatment and Rapid Response Teams (HTRRT) via additional investment from commissioners
- NWL Adult Community Mental Health Team Model (Phase 1).

**cii) Planned activity for Service Redesign for year 2 (2016/17) includes implementation of:**

- NWL Child and Adolescent Mental Health Services Single Point of Access (SPA)
- Physical health checks (for mental health patients) in NWL
- Phase 2: Embedding the new models in our NWL Adult Community Mental Health Teams
- Sexual Health Transformation
- Bed rationalisation of community beds in Milton Keynes (MK)
- Bed rationalisation of adult mental health beds in MK
- Single Point of Referral into adult mental health services in MK
- Transformation of the adult mental health urgent care pathway in MK
- Redesign of the adult mental health pathways in MK.

Additional programmes may come online during the course of the year. Details of these programmes are integrated to our activity plan (Table 5).

**ciii) Engagement around Service Redesign:**

A large element of our service redesign programme involves engagement with stakeholders. This typically takes the form of co-production where staff, patients, carers and commissioners work together to redesign services, putting the patient at the centre of that process.

**d) Recommendation of Carter Review:**

These are touched on elsewhere in the document and the final recommendations will be integrated to existing workstreams around estates (section 4.5), workforce (section 3) medicines management, procurement and data management during 2016/17.

• **Medicines management:**

CNWL has taken part in benchmarking against the Carter criteria for medicines management and where applicable to a non-acute setting, the Trust was not an outlier. Further work will be undertaken next year and the Trust would like to be part of the development of the model, including staffing levels, for non-Acute settings.

• **Procurement:**

The Trust is working collaboratively with the London Procurement Partnership to identify areas where savings through joint procurement can be made.

In terms of medicines management and the Carter Review, all procurement is via regional or national processes where possible which is overseen by the Department of Health for outliers. Local agreements around medicines management are in place with GPs to manage quality and cost between providers.

- **Data management:**

The current ATI metric recommended by Lord Carter is an imperfect fit with services which are more than 90% outside of hospital. CNWL has put itself forward to be one of those involved in adapting the measure for non-Acute settings. As set out elsewhere, CNWL is keen to also work with IST to develop demand and capacity models to support our productivity and efficiency in non-Acute services.

#### 4.4 Proposed Capital Plan for 2016/17

The Capital Plan is in line with the Trust's Strategic Priorities and Plans. The source of capital finance is through internally generated cash (depreciation) and from non-protected asset sales (Non-CRS properties)

**Table 4 – 2016/17 Proposed Capital Plan:**

	£m's
Estates and equipment	9.766
IT	9.783
Loan repayments	0.718
<b>TOTAL CAPITAL REQUIREMENT</b>	<b>20.267</b>

##### a) Estates:

During 2015/16 regular strategic workshops have been established with each Division including clinical staff, to align the property strategy and investments with clinical strategies. Also to optimise use of Estates and management of associated cost such as energy use, in line with the Carter Review (4.4.1d). This work will underpin overall Trust strategy and to deliver ongoing savings. These workshops feed into the Estates Strategy Group which reports to Business and Finance Committee.

This process has) identified Estates-led opportunities for cost reduction which acted as a catalyst for Divisions to consider how they might maximise each opportunity.

A prioritised register of actions, with quick wins for 2016/17, has been identified. These include accelerating improvements and rationalisation of the Milton Keynes portfolio, community service redesign in the Pall Mall building by St Charles, Eating Disorder services and Mother and baby/CAMHS across a number of boroughs.

The Estates and Divisional clinical and property initiatives are being developed into a road map of activities which will form the underlying Estates Strategy for 2016/17 and beyond.

In operational terms, prioritisation and allocation of resources will continue to focus on essential works to reduce or eliminate health & safety risks, with investment to ensure the estate infrastructure is maintained at an appropriate standard and with resources targeted to maximise the utilisation of our estate to improve efficiency and reduce operating costs. Because of careful planning, approximately 87% of the Trust's estate remains in good overall condition, with a low backlog liability.

Planned roll-out of new technology during 2016/17 will facilitate the full introduction of agile working which will mean that we will require less office type space due to the ability of some staff to work remotely; whilst building-based staff can share accommodation in many cases. In conjunction with this we are pursuing partnering with other service providers to share accommodation, such as the NWL Strategic Partnering Group where we are looking at integrated hubs and partnership with other service providers and Local Authorities so that our joint estate is fully utilised.

**b) ICT:**

Linked to opportunities to improve staff and patient satisfaction and treatment outcomes in the context of a 5 year forward vision and digital vision for 2020.

Key programmes for 2016/17:

- Full rollout out of SystemOne
- Ongoing programme lead by CIO to embed and adapt
- The digital road map (how we will achieve digital maturity and paper free at the point of care).
- Launch of Knowledge and Information module

## **5. The next five years - engagement with STPs**

In planning for 2016/17 and anticipating key points of STPs we have considered the following elements:

- Analysis summarised above
- Key Policy guidance (5.1 and Appendix 3)
- Commissioning intentions – locally and nationally (5.2;5.3;5.4 and Appendix 4)

CNWL's objectives for 2016/17 (Table 5) are based on assumption as to what will be in the STP.

Guidance around sustainability and transformation planning is clear that all plans must deliver on the triple promise of the FYFV while meeting a number of criteria from the NHS Mandate and Constitution. These can only be achieved jointly, in partnership across localities. CNWL is a partner in developing place-based STPs in North West London, North Central London and Milton Keynes. Discussions have been commenced in NWL and NCL around the process and content of planning and a request has been sent to Milton Keynes for our involvement there. We are seeking clarification on engagement with the Collaborative Commissioning Hubs to develop STPs for specialised services.

Significant progress has been made through round table discussions between commissioners and providers in NWL and NCL and will be taken into discussion with Milton Keynes Specialised Service as above. Considerations include:

- Ensuring that the plans are fit for purpose in meeting key metrics, for example in relation to cancer, waiting times and the new mental health standards;
- Establishing shared assumptions from which to work, including baselines of population need and provider readiness;
- Together, these are part of discussions to produce plans which will meet emerging requirements for funding via the Sustainability and Transformation Fund (TSF).

Realising the FYFV and Dalton Review will require the establishment of new partnership forms. Together with the development of ACOs as provider vehicles, effective Sustainability and Transformation Plans will move towards addressing the imbalance of demand and resource in our localities. These imbalances are negatively affecting care. They also demand unacceptably high levels of transactional resource through repeated contracting. Integrated planning and delivery will challenge organisational boundaries, and support the Efficiency Opportunity set out in the Carter Review to reduced inefficiency and duplication.

### **5.1 Policy – impact on CNWL planning (Appendix 3)**

Key documents will include those that frame the overall direction of the NHS and those which are subject-related:

- **Framing documents:** The Five Year Forward View; NHS Constitution; The Government's Mandate to NHS England 2016/17; The Comprehensive Spending Review 2015; London

Partners – response to invitation by HM Treasury to submit devolution plans; Locally to CNWL we will continue to see the impact of Transforming London’s Health and Care Together, and Shaping a Healthier Future (SaHF) which redesigned access to A&E in North West London

- **Subject-related:** The Mental Health Taskforce; Future in Mind (CAMHs); For mental health, 2016/17 will see the launch of a NWL strategy for mental health – Like Minded, and a local interpretation of Future in Mind.

## 5.2 North West London STP

### a) Commissioning intentions in NWL:

- **Development of ACOs** (see b)
- **Mental Health:**
  - **Psychiatric liaison:** funding changes may reduce viability
  - Rising demand for **paediatric psychiatric liaison** in London due to changes in access through SaHF
  - **Crisis response** –24/7 access including a Single Point of Access and a Home Treatment and Rapid Response Team (HTRRT) – which are core to CNWL’s redesign 2015/16 and 2016/17
  - Commissioners want to see **reduced inpatient provision** in mental health services – this requires robust alternative provision, also part of redesign
  - Growing demand for **post-traumatic stress disorder** services to meet needs of forced migration population
  - Other consistent items in commissioning intentions for mental health are **Memory Assessment** by GPs **IAPT**, development of **primary care** and **homelessness**.
- **Services for young people and perinatal:** Additional resource will be sought from announced funding. This includes:
  - **CAMHS** and associated **Parental Mental Health**. These are services under pressure, with reduction in local authority funding for tier 2 – non urgent patients. Issue of lack of equity of access to CAMHS services – NSPCC has called this “a national time bomb”
  - **Perinatal** services through NHSE – changes to guidance on admission (full final trimester), length of stay has risen
  - The upper age limit (35) for **Early Intervention in Psychosis (EIP)** is removed from April 2016 (currently 14-35) with considerable organisational and financial implications.
- **Specialised services:**
  - Redesign and tender of **Sexual Health and HIV services across London**
  - Changes to **prisons in London** – now announced. Change period 2016/17
  - **Addictions and Offender Care services** are regularly tendered
  - Development of **community provision for learning disabilities**. In North West London, a commissioner-led Transformation of Care Programme (TCP) has been published on learning disability services. An aim for CNWL in 2016/17 is to increase opportunities for provider engagement in TCPs and other planning vehicles.
- **b) ACO development in NWL:**
  - The existing **early adopters** within the Pioneer programme are likely to progress to ACO status in 2016/17 with anticipated establishment of the ACO in April 2018. CNWL continues to work closely with partners to realise the benefits of integrated care planning and to move towards new legal arrangements for care delivery

- The exception in North West London is **Hillingdon** where there is an accelerated programme to develop an ACO by April 2017. CNWL is a partner with Hillingdon Hospitals NHS Foundation Trust, the GP Federation and consortium of third sector providers, working with the CCG to establish an ACO initially for older people with long term conditions but with a view to this being extended. During 2016/17, a legal entity will be established to translate into an ACO by the deadline
- CNWL will in addition look to further develop our role as a partner in the **Community Independence Service (CIS)** in the Triborough area during 2016/17. This provides support to maintain frail elderly people out of hospital and is complementary to the early adopters in each CCG. CIS is reactive, addressing unplanned need as it arises, enabling the proactive support and prevention work of the early adopters to maintain good overall levels of health and care.

**c) Tariff to support integration:**

- CNWL is one of the providers working with NHSE to define the relative benefits of capitation and year of care funding for people with mental health needs
- We recognise that tariff is not a stand-alone issue – effective use of resource also requires underlying good partnership, effective governance, reliable data, firm contracting and evaluation.

**d) SaHF:**

- Another key strand for London is addressing the impact of closure of A&E under Shaping a Healthier Future – resolving outstanding issues about flow of demand is anticipated to be an aspect of the STP in North West London.

**5.3 Camden within NCL STP**

**a) Commissioning intentions in Camden:**

- Camden Commissioning intentions set out a linked set of goals - review of Acute Care, transformation of the primary care pathway, a focus on mental health inpatient services and review of estates. It is currently anticipated that these will feature in an STP
- Camden community services, run by CNWL, may be tendered in 2016/17, together with a range of other services
- Commissioning intentions outlined under NWL will apply to NCL in relation to services for children and specialised services including perinatal.

**b) ACO development in Camden:**

- Camden was not a Pioneer, but has been at the forefront of developing integrated services and outcomes based commissioning. Camden in NCL has established a number of efficient and effective partnerships which could translate to ACOs. CNWL is involved in a number of these, for example, Mosaic for vulnerable people. We will be looking to work in partnership to take forward ACO opportunities during 2016/17
- Camden will be taking forward integration work through the **London Partners**, specifically modelling estates integration for efficiency – supporting one of the objectives of the Carter Review.

**5.4 Milton Keynes and Bedford STP**

**a) Commissioning intentions in Milton Keynes:**

- Milton Keynes launched a number of new developments in 2015/16 and have a further ambitious set of plans for 2016/17 including **24/7 crisis liaison services**; new **eating disorder** and **memory assessment** services; review of pathways for **respiratory disease** and **diabetes**.
- CNWL's role in an STP for Milton Keynes and Bedford will depend on ongoing discussion around safe levels of funding. Assuming that there is an ongoing role for CNWL in the locality, then key

to the STP will need to be rebalancing the budget across the locality and managing demand so that the high levels of secondary care use are managed

- Commissioning intentions outlined under NWL will apply to Milton Keynes in relation to services for children and specialised services including perinatal
- Tariff work with NHSE as set out under NWL will apply to Milton Keynes.

**b) ACO Development in Milton Keynes:**

- Milton Keynes was a very early ACO and we anticipate that there will be a review and recommitment to ACO working during 2016/17. CNWL is engaged in discussion around this with partners.

## 6 Members and Elections

The trust currently has over 15,500 members across 13 broad constituencies. We have not this year sought to significantly increase its membership but rather to consolidate and concentrate on developing a better engaged and informed membership. We were able to take advantage of the recent change in the model election rules to allow electronic voting. An independent study has found that the Trust was one of the most successful in encouraging people to vote on line with 58% of votes cast this way.

We are currently planning elections for May 2016 in the constituencies below. We will, as in previous years, adopt a hybrid approach enabling people to vote either electronically or by post to ensure the maximum levels of participation so as to boost member voting in elections:

- Service users from the Boroughs of Hillingdon, Harrow, Brent, Ealing Hounslow
- Service users from the boroughs of Westminster K&C, H&F, Camden, Enfield and the rest of the Greater London Authority
- Carers
- Public - London Boroughs Ealing, Hounslow, Hammersmith & Fulham
- Public Milton Keynes
- Public Camden
- Nursing

We must balance regular turnover of governors, with highly beneficial new and diverse perspectives, with the need to ensure they are equipped to carry out their statutory duties. All new governors receive a comprehensive induction concentrating specifically on their role and responsibilities, an introduction to the services provided by the trust including the standards they are expected to meet and an explanation of the financial position of the trust and the wider health economy. All governors are encouraged to visit trust services with a full programme of visits being provided each year.

There is an ongoing programme of education for governors:

- CQC standards
- Learning from mistakes and complaints
- How services are commissioned and the potential future of commissioning
- The role of the Auditor
- Understanding performance and financial information
- Asking powerful questions
- Partnerships in healthcare.

Our Trust website is regularly updated and is the primary source of information about the trust. The public can join the trust online, and access board papers and minutes as well as papers and minutes for the Council of Governors.

The Trust is committed to involvement and engagement and uses a range of opportunities

- Service users on all senior interview panels
- Each service required to have a specific mechanism for collecting service user feedback
- Extensive engagement in development of Trust quality priorities and strategic planning
- Member engagement events
- Embedding experts by experience in the regular workforce
- The Recovery and Wellbeing College - an extensive programme of co-produced courses facilitated by peer trainers and practitioners.
- Open consultation on service change.

**Table 5: Summary of CNWL Operational Plan for 2016/17 as first year of STPs**

Reviewing the environment as set out above, including commissioning intentions, the following areas have been identified as the focus for 2016/7 as the first year of the STP:

Priority area	Activity	Jameson	Goodall	Diggory	Risk and mitigation (Trust Risk Register)
<b>Partnership and Communication</b> <b>Executive Lead: John Vaughan, Director of Strategy and Performance</b>	<ul style="list-style-type: none"> <li>– <b>Partnership:</b></li> <li>• In the 2016/17 Plan, clarify CNWL’s role as a system enabler, values and business model.</li> <li>• Create and communicate a summary for staff, stakeholders and public</li> <li>• Clarify CNWL’s offer – different in each locality</li> <li>• Develop ACOs, ACPs and place-based models of care, new and existing partnerships in UK and overseas</li> <li>• Move to formal partnership and analysis of capability and capacity to support more integrated working – HR, Finance, ICT</li> </ul>	<ul style="list-style-type: none"> <li>– Q1:</li> <li>• STP development with NWL</li> <li>• Potential role in Community Independence Services (Triborough)</li> <li>• Development of integration to become ACPs in 1-3 boroughs</li> <li>• Ongoing role in Like Minded</li> <li>• Delivery of MH Taskforce – integrated to Like Minded</li> <li>• Integration to strategies for Redesign, Workforce, ICT, Estates</li> </ul>	<ul style="list-style-type: none"> <li>– Q1:</li> <li>• STP development with NCL</li> <li>• Decision around Hillingdon ACP – community services to implement Q4 2016/17 / Q1 2017/18</li> <li>• Integration to strategies for Redesign, Workforce, ICT, Estates, Finance (tariffs)</li> <li>• Camden pathway development – dementia, psychosis and urgent care</li> </ul>	<ul style="list-style-type: none"> <li>– Q1:</li> <li>• STP development with MK and Beds.</li> <li>• STP with specialized commissioning hubs</li> <li>• Potential ACP development in Milton Keynes – likely to be significant workstream in 2016/17</li> <li>• Integration to strategies for Redesign, Workforce, ICT, Estate Finance (tariffs)s,</li> </ul> <p>Offender care:</p> <ul style="list-style-type: none"> <li>• extension of dementia screening pilot (Bronzefield)</li> <li>• Extension of EOL network in prisons</li> </ul>	<ul style="list-style-type: none"> <li>• Impact on service delivery and patient experience of organisational change</li> <li>• Internal capacity to change</li> <li>• Financial stability</li> </ul> <p><i>Mitigation:</i>  <i>ACO development led by Director of Strategy and linked to service redesign, financial strategy and QIA process</i></p>

Priority area	Activity	Jameson	Goodall	Diggory	Risk and mitigation (Trust Risk Register)
<b>Transformation and redesign Executive Leads: Dr Alex Lewis, Medical Director (redesign) Trevor Shipman (Tariff)</b>	<ul style="list-style-type: none"> <li>In cooperation with patients, public and commissioners, ensure that CNWL has clear plans for service redesign which assures modern values-based, effective care at competitive cost.</li> <li>Ensure approaches to tariff and payment support delivery of cost effective integrated care</li> </ul>	<ul style="list-style-type: none"> <li>Q3: NWL CAMHS Single Point of Access including tele-triage; improved response and access (NWL access standards).</li> <li>Q4: Agree and implement standards for physical health checks <ul style="list-style-type: none"> <li>Achievement of standards in Planning Guidance and MH Taskforce: <ul style="list-style-type: none"> <li>EIP – 50% seen in 2 weeks</li> <li>IAPT - 75% seen in 6 weeks; access raised from 15% to 25%</li> </ul> </li> <li>Embed new NWL Adult Community MH model</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Q3: NWL CAMHS SPA</li> <li>Revised CPA approach linked to ICT delivery</li> </ul> <p>Q4:</p> <ul style="list-style-type: none"> <li>Hillingdon early adopter and ACP; An integrated practice unit (IPU) in Camden using a Value Based Commissioning approach.</li> <li>Redesign, agree and implement standards for physical health checks</li> <li>Embed new NWL Adult Community MH model</li> </ul>	<ul style="list-style-type: none"> <li>Transform adult MH pathways – psychosis (EIP, AOT, rehab and recovery); specialist services inc Eating disorders</li> <li>Transformation of adult MH urgent care pathway to implement new 24/7 service to include new investment in hospital liaison, street triage perinatal and custody services</li> <li>Unconfirmed community and mental health bed rationalisation with enhanced community provision</li> <li>Single point of referral to MH</li> <li>Transformation programme – Sexual Health and HIV Service for whole trust. Involves public consultation</li> </ul>	<ul style="list-style-type: none"> <li>Redesign programme insufficient to deliver level of change required – inc cost, quality</li> </ul> <p><i>Mitigation:</i></p> <ul style="list-style-type: none"> <li><i>Redesign process clinically led.</i></li> <li><i>subject to formal programme management</i></li> <li><i>QIAs required for all changes</i></li> </ul>

Priority area	Activity	Jameson	Goodall	Diggory	Risk and mitigation (Trust Risk Register)
		<ul style="list-style-type: none"> <li>Agreement of tariff options for MH and other services – year of care/capitation options to underpin integrated care models and the STP</li> </ul>			<ul style="list-style-type: none"> <li>Viability and quality of services <i>Mitigation:</i> <i>Jointly led by clinical and financial heads</i></li> </ul>
		<ul style="list-style-type: none"> <li>Addressing dependency with workforce, ICT and Estates</li> </ul>			<ul style="list-style-type: none"> <li>Dependencies not managed <i>Mitigation:</i> <i>Integrated planning approach via PMO</i></li> </ul>
<b>Workforce Executive Leads: Jane McVey, Director of HR Dr Con Kelly, Medical Director (medical); Andy Mattin, Director of Nursing and Quality (leadership)</b>	<ul style="list-style-type: none"> <li>Ensure the Trust has an able, motivated, productive workforce who feel valued and are available in sufficient numbers.</li> <li>Review medical workforce in line with new models of care</li> <li>Review leadership and management for all non-medical groups</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of workforce priorities:</li> <li>Agency user reduction programme to &lt;8% – led by Director of Nursing and Director of HR</li> <li>Leadership development strategy and development programmes</li> <li>Training and development programmes</li> <li>Recruitment Plan: Further pay rebalancing with bank, incentivisation schemes, apprentice pathway (band 3-4); use of TRAC recruitment processes; staff wellbeing strategy</li> <li>E-rostering – fully rolled out</li> <li>AHP leadership structure revised and in place, particularly in community services and Milton Keynes community</li> <li>Support for an open culture in the organisation, where staff can influence change and hold accountability at the right level</li> </ul>			<ul style="list-style-type: none"> <li>Risk to service quality and cost if unable to recruit and retain engaged high quality staff</li> <li>Use of agency over cap and off-framework</li> <li>Poor quality of care <i>Mitigation:</i></li> <li><i>Action plan around agency use</i></li> <li><i>Recruitment and Retention Strategy</i></li> <li><i>Engagement strategy</i></li> <li><i>Controls in place to ensure only quality assured agencies used to provide temporary staff</i></li> <li><i>Quarterly friends and family test</i></li> </ul>
<b>Finance Executive Lead Trevor Shipman, Director of Finance</b>	<ul style="list-style-type: none"> <li>Finance - To drive clear, effective financial planning within CNWL and as part of localities.</li> <li>Restore and maintain financial balance</li> </ul>	<ul style="list-style-type: none"> <li>Strategy as set out at section 4</li> <li><b>Demand and Capacity</b> – proposed engagement with IST to support development of non-acute methodology. If no IST support, then by Q4 to have agreed, Trustwide D&amp;C management process</li> <li><b>Capital</b> – Q4 – refreshed Estates strategy based on roadmap established through clinical engagement around estates use.</li> <li><b>Contracts:</b> Ongoing contract renewal and renegotiation including new</li> </ul>			<ul style="list-style-type: none"> <li>Financial balance not achieved due to failure to deliver to plan;</li> <li>failure to plan for demand and capacity and cost in 2016/17</li> <li>lack of resource in local health and care economy;</li> <li><i>Mitigation</i></li> </ul>

Priority area	Activity	Jameson	Goodall	Diggory	Risk and mitigation (Trust Risk Register)
	across sectors	<p>partnerships and ACPs Tenders - programme of defense and growth for 2016/17 tenders including IAPT, primary care in prisons, addictions, sexual health</p> <ul style="list-style-type: none"> <li>• Move to shadow tariff in mental health from April 2016</li> <li>• Programme to identify and address variation in cost and against reference costs across CNWL</li> </ul>			<ul style="list-style-type: none"> <li>• Approach as set out</li> <li>• Monthly reporting to Board via B&amp;F and to Monitor inc CIPs</li> </ul>
<p><b>A revised ICT strategy</b> <b>Executive Leads:</b> <b>Trevor Shipman;</b> <b>Mark Large,</b> <b>ICT Director</b></p>	<p>– Linked to opportunities to improve staff and patient satisfaction and treatment outcomes in the context of a 5 year forward vision and digital vision for 2020.</p> <p>Key programmes for 2016/17:</p> <ul style="list-style-type: none"> <li>• Full rollout out of SystmOne</li> <li>• Ongoing programme lead by CIO to embed and adapt</li> <li>• The digital road map (how we will achieve digital maturity and paper free at the point of care).</li> <li>• Launch of Knowledge and Information module</li> <li>• Review of CPA and SystmOne</li> </ul>				<ul style="list-style-type: none"> <li>• Lack of alignment service redesign/ clinical system programme. Quality and financial implications</li> <li>• Loss or corruption of patient records could be a major incident.</li> <li>• Dependencies not managed</li> </ul> <p><i>Mitigation:</i></p> <ul style="list-style-type: none"> <li>• CIO in post. Tight governance including services, CFO and COO</li> </ul>

## Appendix 1: Public Health overview – Health Indicators: 2015

Significantly worse than English average	Significantly better than English average
<ul style="list-style-type: none"> <li>• <b>Brent:</b> Deprivation, Children in poverty (under 16s), Statutory homelessness, Violent crime (violence offences), Long term unemployment, Obese Children (Year 6), Recorded diabetes, Incidence of TB, Acute sexually transmitted infections, and Under 75 mortality rate: cardiovascular</li> </ul>	<ul style="list-style-type: none"> <li>• Smoking and smoking related deaths; admissions to hospital related to alcohol (under 18) obesity in adults; under 18 conception; life expectancy, under 75 mortality rate for cancer, hospital stays for self-harm</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Harrow:</b> Recorded diabetes, Incidence of TB, obesity in children and physical activity in adults.</li> </ul> <p>However, infant mortality has moved from being significantly worse than the English average in 2014, to about the same</p>	<ul style="list-style-type: none"> <li>• Deprivation, Children in poverty (under 16s), Statutory homelessness; violent crime, smoking, self-harm, alcohol related admissions, drug misuse, acute sexually-transmitted infections, drug misuse, life expectancy, under 75 mortality rate: Cardiovascular and cancer, hospital stays for self-harm</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Hillingdon:</b> Children in poverty (under 16s), homelessness, Violent crime (violence offences), Recorded diabetes, Incidence of TB, Acute sexually transmitted infections.</li> </ul>	<ul style="list-style-type: none"> <li>• Deprivation, , homelessness, unemployment, breastfeeding, self-harm, hospital stays related to alcohol, drug misuse, life expectancy, hospital stays for self-harm</li> <li>• However, obesity in children has moved from significantly to about the same as the English average</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Kensington and Chelsea:</b> Deprivation, Children in poverty (under 16s), Statutory homelessness, Violent crime, Drug misuse, Incidence of TB, obese children, sexually transmitted infections, Killed and seriously injured on roads.</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term unemployed, breastfeeding, obese children (year 6), smoking, obesity in adults, hospital stays related to alcohol, recorded diabetes, life expectancy, under 75 mortality rate: Cardiovascular and cancer, hospital stays for self-harm</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Westminster:</b> Deprivation, Children in poverty (under 16s), Statutory homelessness, Violent crime (very high), Obese children (Year 6), Drug misuse, Incidence of TB, sexually transmitted infections, Killed and seriously injured on roads.</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term unemployed, smoking, breastfeeding, obese children (year 6), self-harm, hospital stays related to alcohol, life expectancy, under 75 mortality rate for cancer, hospital stays for self-harm</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Milton Keynes:</b> Statutory homelessness, Violent crime (violence offences), Breastfeeding initiation, Excess weight in adults, Life expectancy at birth (Female).</li> <li>• However, life expectancy at birth (Males) has moved from much worse to the English average)</li> </ul>	<ul style="list-style-type: none"> <li>• Deprivation, , long term unemployment, drug misuse, hospital stays for self-harm and sexually transmitted disease</li> <li>• However, children living in poverty and recorded diabetes have moved from much better to about the English average</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Camden:</b> Deprivation, Children in poverty (under 16s), Violent crime (violence offences), Drug misuse, Incidence of TB, Acute sexually transmitted infections, Killed and seriously injured on roads.</li> </ul>	<ul style="list-style-type: none"> <li>• Homelessness, long term unemployment, alcohol related admissions, breastfeeding, hospital stays for self-harm, diabetes, life expectancy</li> <li>• However, obesity in children has moved from being significantly better than the English average in 2014, to about the same</li> </ul>

SOURCE: Public Health of England - Health Profile (2015).  
[http://www.apho.org.uk/default.aspx?QN=HP\\_FINDSEARCH2012](http://www.apho.org.uk/default.aspx?QN=HP_FINDSEARCH2012)

## Appendix 2– QIA criteria:

Compliance	<ul style="list-style-type: none"> <li>• <i>Potential impact on ability to meet Monitor compliance requirements, contractual requirements or CQC registration standards</i></li> </ul>
• Patient Access	<ul style="list-style-type: none"> <li>• <i>Potential impact on patient access to appropriate care / treatment; waiting times; on travelling times for patients</i></li> </ul>
• Experience	<ul style="list-style-type: none"> <li>• <i>Potential impact on level of patient satisfaction; number of justified complaints.</i></li> </ul>
Effectiveness	<ul style="list-style-type: none"> <li>• <i>Potential impact on patient outcomes; modernisation plans; NICE compliance; other policy or best practice requirements; staff capability, effectiveness and productivity of the service</i></li> </ul>
• Safety	<ul style="list-style-type: none"> <li>• <i>Potential impact on health or safety of patients number of serious incidents; number of incidents and severity of incidents</i></li> </ul>
• Training	<ul style="list-style-type: none"> <li>• <i>Potential impact on training for junior Doctor training or training requirements for clinical and nursing staff.</i></li> </ul>

## Appendix 3

### Policy – impact on CNWL planning

There are a number of key documents which will affect planning and delivery in 2016/17:

- **The Five Year Forward View** – new models of care, prevention and choice agenda. Has driven development of Accountable Care Organisations at pace during 2015/16 and this will accelerate in 2016/17 through Vanguards and maturation of other integrated care models, as well as the impact of the Carter Review on productivity and reduction of waste.
- **NHS Constitution** – the seven principles of the Constitution and its values have been considered and reflected in setting our plan for 2016/17 (Table 5).
  - Principles: the NHS is comprehensive; based on need not ability to pay; excellent and professional; with the patient at its heart; able to work across boundaries; value for money, and; accountable.
  - Values: Everyone can expect NHS staff to work together for patients; show respect and dignity; be committed to quality of care; compassionate; focussed on improving people’s lives and; clear that everyone counts.
- **The Government’s Mandate to NHS England 2016/17** – for CNWL as a provider, key elements of delivery will be avoidable deaths and seven day services; balancing the NHS budget; obesity and diabetes; dementia; Referral to Treatment; new models of care; research and growth; technology, and; health and work. Again these are reflected in our one year planning, and will inform our development of STPs.
- **London Partners** – response to invitation by HM Treasury to submit devolution plans.
- **The Comprehensive Spending Review** – has a strong health focus for 2016/17. Providers will not automatically see these funds reach the front line so this will be part of contracting discussions.

The CSR also announced £600m for mental health talking therapies, which will be clarified when the Mental Health Taskforce presents on its finding.

- The finding of the the **Mental Health Taskforce** has been announced with investment of £1bn in services for a further 1million people. To include a number of new standards to be put in place now, as well as goals for 2020. The report provides practical support in relation to all the key areas of concern for mental health providers – access to IAPT and work; physical health care; more support to complex needs such as eating disorders; a focus on children, young people and perinatal services; crisis response; suicide; and patients travelling long distance to access beds. Also, for this to be supported by a firm and growing research base and improved data to support delivery of efficient, effective, good quality care.
- **Future in Mind** is impacting on redesign of CAMHS services, again complemented by funding, during 2016/17. This will be influenced by an NSPCC report re inequality of access to mental health services.
- Locally to CNWL we will continue to see the impact of **Transforming London’s Health and Care Together**, and of course **Shaping a Healthier Future** which redesigned access to A&E in North West London. This has had a significant impact on demand for CNWL (see section 2 on demand). For mental health, 2016/17 will see the launch of a NWL strategy for mental health – **Like Minded**, and a local interpretation of **Future in Mind**.

## Appendix 4:

### Commissioning intentions - impact on CNWL planning

Together with the policy framework, commissioning intentions 2016/17 frame our plan. We anticipate that they will form the basis for further work within the developing STPs (section 5):

- **ACOs:** In terms of new models of care, the next year will see progress of integrated care planning, including North West London’s Pioneer pilot, into new organisations –ACOs. These are implicit rather than explicitly stated in commissioning intentions. However they are emerging and CNWL is fully engaged around partnership to develop ACOs
- **Specialised and Public Health England services:**
  - Redesign and tender of **Sexual Health services across London** has been brought forward from the anticipated date of 2017/18. The programme will tackle rising demand and cost, through a programme to increase internet access and self-diagnostic packs, and decrease the number of centres from which these services are provided. A similar exercise in relation to HIV will take place next year or the year after
  - **Addictions and Offender Care services** are regularly tendered. During 2015, the announcement was made to close Holloway Prison and move to a new provider which will impact on CNWL staff working there during 2016/17
  - **Eating Disorders:** With the move to local commissioning, there is growing trend for reluctance to admit people with complex and severe eating disorders locally. This has a poor impact on quality of care and use of Acute beds. CNWL will seek to address this with commissioners for 2016/17.

- **Learning disabilities:**
  - CNWL's service for people with a learning disability has some beds for intensive care but primarily focuses on community solutions in partnership with local authorities and the third sector. This work includes a model of intensive support to keep people living at home with more support over a short or longer term period. The Mosaic service in Camden brings together a range of providers, coordinated by CNWL, to provide services to young people up to 25, with a strong support and prevention focus. In North West London, a commissioner-led Transformation of Care Programme (TCP) has been published on learning disability services including facilitating more support in the community to reduce use of specialised care in hospital. An aim for CNWL in 2016/17 is to increase opportunities for provider engagement in TCPs and other planning vehicles
  
- **Mental Health:**
  - **Psychiatric liaison:** Commissioners announced a split of funding for Psychiatric Liaison between CCGs (for A&E) and Acute Trusts. This presents some risks to teams which may become unsustainably small
  - There is also a rising demand for paediatric psychiatric liaison as a result of the closure of Ealing A&E through Shaping a Healthier Future. This has increased demand in St Mary's and Chelsea and Westminster
  - **Crisis response** – CNWL has a programme of redesign which has focussed in 2015/16 on crisis response with the launch of a single point of access on November 3rd 2015. This provides 24/7 access through Single Point of Access and a Home Treatment and Rapid Response Team (HTRRT). Redesign of community services is already providing further resource for 24/7 home visits
  - Commissioners want to see **reduced inpatient provision** in mental health services. This is part of wider redesign for CNWL and we are working with commissioners. Once a robust community and primary care provision is in place then a shift away from demand for beds is anticipated
  - There is a growing demand for **post-traumatic stress disorder** services. With a growing refugee population in Brent, a need is being considered to extend the Westminster Forced Migration and Trauma Service. Research into refugee populations shows that, depending on the sample, the rates of PTSD may reach as high as 86% for PTSD and 31% for depression
  - Other consistent items in commissioning intentions for mental health are **Memory Assessment** by GPs **IAPT**, development of **primary care** and **homelessness**.
  
- **Services for young people and perinatal:** Additional resource will be sought from announced funding. This includes:
  - **CAMHS** and associated **Parental Mental Health**. These are services under pressure, particularly with the reduction in local authority funding which has reduced services to tier 2 – non urgent patients. The NSPCC has recently published evidence that 1 in 5 of those presenting to CAMHS are not meeting the threshold or are waiting for a long time – with the gap in secondary care putting pressure on secondary care. The NSPCC has called this a “mental health time bomb”. We continue to see admissions to adult wards of young people under 18 due to lack of beds nationally.
  - **Perinatal** services are commissioned through NHSE, and last year the Coombe Wood Mother and Baby Unit changed admission criteria to admit women in their final trimester. This service is under resourced to provide this currently.
  - The upper age limit (35) for **Early Intervention in Psychosis (EIP)** has been removed from April 2016 (currently 14-35) has considerable organisational and financial implications.