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NHS Haringey
NHS Islington
The Whittington Hospital NHS Trust

Contractual Transfer (Externalisation) of NHS Haringey and NHS Islington's Community Service APOs ("The Alliance") to The Whittington Hospital NHS Trust

FULL BUSINESS CASE

Author: Programme Team

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Document Control

Document Purpose

The Full Business Case acts as the key document for PCTs Boards approval of the formation of the Integrated Care Organisation. Once the FBC is approved, formal staff consultation may start.

This FBC aims are to:

- Obtain Boards' commitment and formal approval for the transfer of the APOs into The Whittington Hospital NHS Trust and the formation of the Integrated Care Organisation (ICO).
- Provide a framework for planning and management of the transaction.
- Monitor the ongoing viability of the programme against the Business Case.

Document Owner and Contributors

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Document Preparation

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Sign Off Form

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1. EXECUTIVE SUMMARY

The 1st April 2011 will mark the creation of a new Integrated Care Organisation (ICO), bringing together the Whittington Hospital NHS Trust and Community services from NHS Islington and NHS Haringey. This provides substantial opportunities to work across historical organisational boundaries to deliver care that is centred on the needs of the local population. Integrating our clinical teams across acute and community services and changing both how we work together, train together and how we support our patients, presents a real opportunity to achieve the dual aim of improving quality of care and reducing cost, and therefore a mechanism to achieve clinical and financial sustainability.

Whilst integration of community and acute health services defines the new organisation, in order to deliver the vision of improved health outcomes for our local population, close partnership with colleagues in primary care and social care is essential. In addition, maintaining the strong borough basis, building upon existing integrated arrangements with the Local Authorities will ensure that prevention and health promotion are also core to our work.

The approach is consistent with the future NHS policy context, encompassing the recognition that patients need to be at the centre of services, facilitating close working between all aspects of health provision and social care, and providing new incentives and opportunities to deliver step changes in population health.

For patients: There is a real opportunity to ensure that the patient is at the centre of how services are delivered, by moving away from historical institutional boundaries and focussing on personalised care, which is tailored to each individual patient. Patients will have access to a full range of high quality care both in the hospital and in a community setting, and experience more linked up services across settings. Where appropriate, patients will also have a greater choice over where they receive their treatment, either in the hospital, in their GP surgery, a health centre or in their home

For the local population: We will find a sustainable model of providing services that are required locally and building on the strengths of the combined entities of the Whittington and community services in Islington and Haringey. We will be available for people when they need us to support both planned and urgent health care needs

For staff: By working across settings of care there are new opportunities for role development and career progression, and accompanying opportunities to change and enhance the nature of training and education. In addition, staff will be more empowered to source the care that is most appropriate for the patient through better care co-ordination and case management across the full patient pathway.

Delivering the vision for the new organisation will be made possible through underpinning changes in how we manage and provide care. In particular facilitating:

- **Changes in how care is delivered:** where possible providing more care outside of the hospital setting; not by retrenching, but by deliberately setting out to re-shape the way care is provided for many common and long-term conditions. Clinicians from different disciplines and historically different settings will be encouraged to work together to break down barriers that have traditionally gotten in the way of the best care for patients. The ICO will be committed to putting the patients, not organisations, at the centre of defining how care is delivered
- **Changes in clinical practice:** ensuring delivery of agreed protocols across the full patient pathway, with more joint working and more teaching and training across disciplines

- **Organisational development:** to ensure that the different cultures of our organisations are renewed by the shared vision for integration of service provision, and commitment to change how we work to achieve it
- **Shared information:** with providers sharing common patient-level information to support consistent approaches to delivering care and providing an opportunity for clinicians to review and agree the best path of treatment for patients
- **Joint governance and incentives:** creating one organisation across acute and community provision ensures that historical organisational boundaries can be overcome, to allow teams to work together to jointly manage agreed care pathways for patients, and to smooth the transition for patients as they move between settings of care.

The governance arrangements for the ICO will ensure that GP Commissioners are fully involved in the strategic direction of the ICO. The ICO will therefore be in an excellent position to take advantage of the wider changes in Commissioning and GP Consortia from 2012. These changes will directly impact on all NHS Trusts but during its first year the ICO will work to align itself with consortia priorities and build positive relationships going forward into the new commissioning landscape

Support has been gained to date from the Alliance Joint Provider Board, local commissioning organisations and key stakeholders, all of whom recognise the appropriateness of the proposed ICO for meeting the future healthcare needs of the local population. We are confident the new organisation will be large enough, and flexible enough, with strong business arrangements to stand on its own, tested by gaining approval from Monitor to be a Foundation Trust by 2013. This will provide institutional sustainability and financial freedom to invest in care and developing staff.

This document provides further details on our vision, our short term priorities to ensure successful transfer of services and transition arrangements, and an overview of how we will ensure the model is successful, by encompassing organisational development and service transformation into our approach from the beginning.

We are excited by the opportunity deliver real changes where appropriate that will make a difference for the patients we care for and the populations we cover.

2. CASE FOR CHANGE

2.1 VISION

The vision is to create a new organisation that integrates secondary care and community services to improve pathways, whilst remaining a local health provider serving local people. The ICO will be an autonomous financially viable organisation able to compete in the local healthcare market place. This new Integrated Care Organisation will work with primary care and social services partners to:

- Improve the health and well-being of all residents of Islington and Haringey;
- Improve the health care of all who fall ill, seeking to give patients greater authority over their own lives and treatment, preferring to treat them in their own homes wherever appropriate rather than in health institutions;
- Provide 24/7 access to a full menu of appropriate high quality care, including acute care for those that need it, and care in a community setting supporting health, well-being and independence in the home;
- Reduce health inequalities throughout both boroughs;
- Reinforce the role of local GPs at the heart of health and well-being services;
- Work closely with all local public services, voluntary organisations and businesses to deliver this vision as partners;
- Break down artificial institutional barriers between all service delivery organisations through a radical rethink of care pathways;
- Develop innovative training and education opportunities;
- Seek to become a Foundation Trust with a substantial, involved and active membership;
- Aspire to be recognised as a beacon ICO delivering innovative and personalised services with choice focussed around patients, GPs, NHS staff and partners
- Be a cost effective and efficient organisation.

2.2 ORGANISATIONAL PRINCIPLES

The ICO will:

- Put patients first. Offer a first class experience to patients, act on patient feedback and comments and involve patients in all decisions about services and care;
- Provide high quality and safe services which perform in the top decile nationally;
- Value and develop staff so that the ICO becomes the local employer of choice;
- Provide high quality training and education opportunities;
- Establish and maintain robust clinical and corporate governance arrangements;
- Make best use of NHS resources, provide cost effective services and offer value for money to commissioners;
- Work with local partners to improve the health of the local population.

In particular, the organisation will do things differently in the following ways:

- Redesigning care pathways and enabling care closer to home to reduce unnecessary hospital visits or admissions and reduce the length of stay;
- Improve access to care in deprived areas;
- Improve co-ordination around discharge and support earlier discharge;
- Increasing capability to maintain patients in the community by bringing acute care skills into the community;
- Supporting more people to maintain their own health by further developing skills and approaches to self management such as telehealth;
- Building on and strengthening partnerships and interfaces with GPs, other NHS Providers, local authorities and the third sector including providing more integrated care packages
- Linking services more effectively across Haringey and Islington to benefit from economies of scale;
- Becoming even more customer focused and doing more to both invite feedback and act upon it;
- Using a population focus to risk assessment with risk stratification based on practice lists;
- Care planning and case management with joint review by primary and secondary care clinicians;
- Focus on education and quality improvement.

2.3 PROPOSED GOVERNANCE ARRANGEMENTS

2.3.1 Management structure

The management structure will be reviewed to deliver better integration of services in the future, to support and invigorate transformation of services. The aim of the organisational structure will be to deliver the Trust's key objectives through:

- Enabling the delivery of safe and effective patient/user services
- Supporting the transformation of community and acute clinical services
- Supporting actions to address inequalities in health
- Facilitating increased productivity
- Enabling the ICO to achieve foundation trust status
- Enhancing working across boundaries including local authorities, local commissioners and other neighbouring partners
- Providing value for money

2.3.2 Interim management structure on 1 April 2011

It is important that there is stability within the management of services to retain valuable expertise and experience to use as a springboard for future change. To facilitate this, Islington and Haringey Community Services will join the Whittington Hospital NHS Trust an interim separate community directorate led by its Chief Operating Officer. The overall aim will be for a smooth transfer of community services to the ICO.

2.3.3 Post April 2011

Following this interim arrangement, it is proposed that there will be two strands of work; review of patient services and review of corporate services. To support the transformation of community and hospital services, it is proposed that within the first year of the ICO three directorates will be created consisting of Scheduled Care, Unscheduled Care, and Women and Children's services. These will be reviewed in a systematic way with a view to aligning them through patient pathways to deliver improved integrated services.

2.3.4 Integrated governance with local authorities and primary care

The ICO will be a truly integrated organisation encompassing secondary care, primary care and social care across Haringey and Islington. Section 75 agreements will be reviewed for due diligence purposes as part of the Business Transfer Agreements and all will be legally constituted and transferred to the new organisation.

Although discussions and integrated governance arrangements are still to be concluded, options under considerations including establishing a new Partnership Board will full local authority and GP as well as representation from the ICO Board. Alternatively, the newly constitutional Health and Well Being Committee could be utilised. In either scenario, the overview and scrutiny functions of both councils would provide the forum for external accountability of performance.

2.4 SECTOR SERVICE STRATEGY

The proposal to integrate the community services of NHS Haringey and NHS Islington with the Whittington Hospital was formally approved by the North Central London Sector on 23 September 2010. Stage 1 approval involved an assessment against the *'National Tests'*, with an emphasis on strategic fit, stakeholder engagement, a credible receiving organisation that could deliver on the quality and value for money agenda and a solution that could be implemented by April 2011.

NHS North Central London also carried out a 'strategic fit' review during July 2010, which reaffirmed its support for NHS Islington's decision.

2.5 BENEFITS OF THE ICO

The creation of the ICO brings together the different strengths of The Whittington and The Alliance to form an organisation that will enable multiple benefits for patients, provider staff and the wider health economy.

2.5.1 Key benefits for patients

There will be tangible benefits for patients based on improved care co-ordination and communication across services, increased capacity and streamlined pathways, all of which will lead to an improved patient experience. In detail these will include:

- Greater continuity of care and improved patient safety through improved communication between clinicians across the ICO, using a common electronic patient record and through clinicians working across secondary care and the community;
- Fewer handoffs between clinicians with fewer duplicated assessments and tests;
- Faster access as capacity is freed up from reducing duplication of appointments across secondary care and the community;
- Care closer to home with fewer visits to hospital and emergency admissions;
- Saving patients' time by offering appointments in more convenient places and merging IT so that records can be shared across different sites;
- A greater focus on long-term conditions and self care;
- Clinicians who are engaged in the prevention agenda;
- Better educated clinicians, trained in inter-professional care;
- A greater focus on prevention programmes;
- Engaging with patients to ensure we provide the information they need to make informed decisions on treatment choices;
- Better signposting for patients so that people can navigate the health system more easily.

2.5.2 Cases studies – benefits of the new organisation

Case study 1 – integrated teams and focus on self-care

Mr Green is a 75 year old gentleman who has a long standing history of heart failure, which has steadily declined. He has become almost housebound due to symptoms of breathlessness and gross swelling to both legs. Mr Green's GP had been very involved in his care and felt that an admission was required to optimise his therapy. However, as Mr Green has already been in hospital twice this year he was not been keen to be admitted again and refused.

The GP referred Mr Green to a community Heart Failure Nurse Specialist (HFNS) who undertook a comprehensive assessment in his home and worked with both the GP and the Consultant Cardiologist to manage his symptoms and coordinate his care. His medication was altered following advice from the Consultant Cardiologist and the effects monitored closely. As the HFNS is an independent Nurse Prescriber changes to medication could be made promptly and Mr Green felt more involved when the use of Telehealth further enhanced his care during the early stages of his management at home without the need for the HFNS to make daily visits. By working in partnership with Mr Green, using the care planning approach adopted through the Co-Creating Health programme, the HFNS was able to build rapport and support him in enhancing his self management skills, preventing further hospital admission, and increasing his understanding of when he does need to call for help. Telehealth provided the nurse with access to regular biometric assessments of blood pressure, heart rate, oxygen saturations remotely, and supported self management by prompting Mr Green to take his medication.

Case study 2 – reducing emergency admissions

Mrs Palat is 85 years old and lives alone since her husband died a year ago. She has a medical history of arthritis and spondylitis of the cervical spine.

She fell at home and was on the floor for several hours when she was found by her friend who visits once a week. Her friend was concerned that Edna was in pain and unable to get up on her own so she called for an ambulance. It emerged that she had been finding it difficult to cope in the two months prior to this fall and that she was taking much longer to get about. She had had falls in the past but had not told anyone about them, as she was worried she would be told she could not stay in her own home.

The ambulance took her to the Urgent Care Centre where following triage from the Emergency Nurse Practitioner and normal X-rays, the Consultant in Elderly Care medicine established that whilst Edna needed a period of assessment and treatment, this did not need to be in a hospital setting. The Rapid Response team (RRT) therefore arranged for Mrs Palat to be admitted to one of the dedicated intermediate care step up beds in a nursing home.

The intermediate care team quickly got to work with Mrs Palat and within the first 24 hours set goals to help her confidently back on her feet as soon as possible and with the aim of getting her home within two weeks. During her first week in home, the team arranged:

A meeting with Mrs Palat and her friend to come to a decision on what support she will need at home. She liked the idea of a falls monitor and adaptations to her home to help her get around

Intensive physiotherapy to learn exercises she could continue with at home to build her strength and reduce the likelihood of falling again.

A visit to her home with key people from the RRT team to try out the new adaptations to her home. Mrs Palat went home 2 weeks later with the support of the Re-ablement service to continue ongoing management of goals and to progress with enabling the care provision to prevent ongoing admission into long term care.

Case study 3 – care co-ordination

Mrs Brown is a 76 year old lady with diabetes and hypertension who lives alone independently. She attends her GP practice complaining of increased pain on walking. Her GP suggests a hip replacement and discusses potential providers from the Choose and Book website. Mrs Brown chooses the Whittington hospital and the GP sends a referral to a named consultant, Mr Johnson and explains that her case manager will be Charlotte Dale. She is given a card with Charlotte's name and contact details.

Mrs Brown has all her pre-assessments completed in the community with her GP and a community nurse. She attends hospital on the day of her procedure and has a short length of stay without problems. Mrs Brown is discharged home and has daily telephone calls from Charlotte who also co-ordinates the community rehabilitation team.

Case study 4 - greater continuity of care

David is a 5 year old boy who suffers from frequent acute asthma attacks. Over a 12 month period, his mother had taken him to A&E on five occasions, but so far, he has not had to be admitted to hospital. At his last presentation, he was seen by the clinical navigator at the front of the Urgent Care Centre. She noticed that David's weight was significantly above the top centile for weight for his age group. He was triaged to see a Children's Nurse Practitioner who, once she had assessed and stabilised his asthma, then assessed his weight and diet.

The nurse offered them information about the Healthy Eating Management programme at his Primary School and asked the ICO Children's Asthma Specialist Nurse to work with David and his mother to review his medication and to make sure he was using his inhaler properly.

They developed a care plan which David's mother had a copy of, which described what the family should do if he started to feel unwell; this was shared via EMIS Web with the GP practice. The Children's Asthma Specialist Nurse also met with family's Practice Nurse and GP and offered training to the whole practice team in supporting David and his mother in managing his asthma with the option also of doing some joint clinics to embed skills.

Over the next six months, David's asthma became much better controlled and he had no visits to A & E. He also began to achieve a more normal weight for his age.

2.5.3 Key benefits for partners

A variety of benefits will exist for our main partners, commissioners, GPs, and local authorities.

Commissioner benefits:

- Improved advice to the commissioning process and to GP commissioners;
- Options to introduce incentives to keep patients out of hospital by use of population-based or HMO models of funding;
- Reduced community and acute management and support function costs through economies of scale with a single organisation;
- Streamlined, redesigned clinical pathways;
- Reduced emergency admissions through enhanced urgent care pathways, improved clinical risk management and community integration;

- Separation of PCT commissioning and providing functions with the formation of a viable and competitive foundation trust.

Primary care benefits:

- Use of a common electronic patient record across secondary, community and primary care enabling real-time transfer of clinical records and discharge information;
- Access to integrated services needing less liaison and co-ordination by GPs;
- Faster access to services which reduce the demand for GP appointments.

Local authority benefits:

- Wherever possible shared electronic information systems
- Further opportunities for integrated work across Haringey and Islington Health and Local Authority services, and to reduce duplication, increase efficiency and reduction in costs;
- Opportunities to work together on prevention to manage demand for services;
- Bigger economies of scale to reduce management costs.

2.5.4 Key benefits for staff

There are a number of opportunities and benefits for staff of working in a larger, more diverse organisation, these include:

- More career opportunities and enhanced roles across secondary and community care;
- Increased opportunities for training and professional development;
- Staff understand better services so they are more efficient in supporting service users to navigate the system;
- Staff work much less in silos
- Opportunities to learn secondary and community care skills around clinical risk management, prevention and self care, acute care skills;
- Wider role for clinical leaders across integrated teams;
- Specialist advice and expertise more readily available to teams;
- Access to research advice and support for community staff.

2.5.5 Key benefits for the organisations

- Integrated vision, planning, and decision making – better understanding of the consequences of decisions; faster decisions
- Reduces spending -funding goes a longer way when it is pooled to achieve a common agreed goal and outcome
- Integrated pathways and seamless/interdisciplinary working – improved productivity

- Review of patient pathways leading to quality improvements
- Integrated management and leadership
- Wider and enhanced education opportunities
- Inter-professional collaboration
- Supports the achievement of performance indicators
- Improves trust and commitment at all levels
- Allows for consistent communication
- Learning from each others organisations strengths
- Utilisation of existing business systems across the ICO, such as service line reporting
- Brings cultures closer together

2.5.6 Benefits resulting from Foundation Trust status

As previously stated, the ICO will aim to become an NHS Foundation Trust, which will confer greater freedoms and flexibilities than an NHS Trust, specifically:

- Freedom from performance management by SHAs.
- Freedom to access capital on the basis of affordability instead of centrally controlled allocations.
- Freedom to invest surpluses to developing new services
- Freedom to develop flexibility governance arrangements to suit the individual circumstances of their local communities.

In line with the programme of reforms set out in the NHS Plan, FTs can give more power and a greater voice to their local communities and front line staff over the delivery and development of local healthcare. NHS FTs have members drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

We will use the experience of our local authority partners to ensure we engage with our communities in a meaningful way and allow our community members to articulate their views as the new owners of our services.

2.6 QUALITY IMPROVEMENTS

As part of our Post Merger Implementation Planning, the ICO Clinical Governance workstream contains a number of projects and tasks aimed at aligning current systems of quality and governance in the hospital and community health services.

On 'day one', plans will be in place to ensure that existing quality programmes report via a single route to the ICO Board. Following the transfer of services these programmes will be integrated into a single approach to quality that is consistent with a robust Monitor / FT approved framework.

Quality improvements are demonstrated for the Alliance services in the Alliance's Quality Improvement Work Plan, which covers three main domains – Safety, Clinical Quality and Patient

Experience – and is monitored and reviewed on an ongoing basis by the Quality and Workforce Committee and the Joint Clinical Governance Committee.

The Whittington Hospital currently monitors and reviews all aspects of quality through a range of committees, including the Clinical Audit and Effectiveness Committee, the Patient Safety Committee and Patient Experience Work streams, which report through to the main Trust Clinical Governance Committee. The Whittington Hospital recently produced its first Quality Account for 2009/10, which included priorities for 2010/11, as well as information on the quality and safety of services and feedback from patients.

Staff from the Alliance and from the Whittington Hospital are working together under the ICO Transformation Workstream using learning from best practice and other pilots to establish a number of pathway demonstrators which will provide evidence of the quality improvements achieved through integration of services around improved clinical pathways.

2.6.1 Service quality

A number of continuous improvement activities are being monitored in response to the QIPP agenda in both existing organisations, and the integration work will merge these into one programme post April 2011.

i. Alliance

The Alliance Head of Research and Innovation has supported innovative working practice and has worked with staff and teams to support and enable them to implement original and novel ideas for service improvement.

These innovation projects are all at different stages of development. An example of an innovation, which has passed into business as usual, is the use of daily teleconferences by intermediate care services in both Islington and Haringey. Teleconferencing covers local hospital sites and involves senior staff with the aim of improving discharge planning and reviewing whole system bed capacity. This has resulted in significant reductions in delayed transfers of care.

Productivity projects have been developed using a number of different approaches, including LEAN training, Releasing Time to Care and Productive Community Services. A successful bid for SHA development funding allowed the Alliance to train up a number of LEAN Champions to work with services on different areas of focused improvement work.

The Alliance also has a Health Promotion Strategy, which requires services and frontline practitioners to promote self-care and to:

- Embrace a philosophy that promoting health and wellbeing and reducing inequality is every practitioner's role;
- Make use of every contact as an opportunity to tackle lifestyle factors; and
- Know the range of interventions, which promote positive behaviours.

In order to ensure that these different elements of the QIPP agenda are being applied where they are needed most, the Alliance is developing a diagnostic tool to be used with services. The tool will help highlight specific teams and areas where focused support and intervention will have the maximum impact, and whether the focus should be on innovation, productivity or prevention.

ii. Whittington Hospital

The Whittington works to ensure that all services are of a high quality and monitors against a wide range of targets to assess this. In addition, priority areas are identified through patient feedback, national initiatives and service audit and review, for further improvements. More recent initiatives have included:

- Use of an acute admissions unit for emergency patients to support reductions in lengths of stay (with further expansion of the unit imminent to take all adult acute admissions);
- Opening of a new birthing centre to provide a low-tech, low stress birth environment;
- Reducing outpatient appointment changes to support reductions in DNA rates;
- Provision of some evening and weekend clinics to provide a wider range of outpatients appointment times;
- Extension of the out-of-hours endoscopy service to run 24/7;
- Implementation of the productive ward programme.

A number of CQUIN (commissioning for quality and innovation) schemes are in place for 2010/11, monitored through a monthly reporting cycle.

iii. Joint Services

In July 2008 a joint application from Islington, Haringey and the Whittington succeeded in being one of the eight sites nationally to take part in the Health Foundation's three-year Co-Creating Health initiative. This programme takes a whole systems approach to transform the patient-clinician interaction into a collaborative partnership. The focus locally has been on type 2 diabetes, and an additional two years funding was agreed in September 2010. This approach to self-management will form good practice basis for developing and delivering service changes for other long term conditions.

2.6.2 Patient safety

i. Alliance

The safety domain of the Alliance's Quality Improvement Work Plan tracks improvements delivered as part of:

- Our NHSLA action plan,
- Learning from complaints, incidents and claims, and reviews arising from Serious Incidents (SIs) and prison healthcare Deaths in Custody (DICs), SIs/DICs are monitored utilising the SI Tracker for the Alliance;
- Our infection control structured audit programmes in both Haringey and Islington;
- Audit programmes around falls, nutritional screening and pressure ulcers in our inpatient unit;
- A structured programme of participation in National, Regional and locally conducted audits;
- Safeguarding Vulnerable Adults and Children action plans;
- Ongoing training/CPD for clinical staff over and above mandatory requirements as required by our Nursing and AHP Strategies.

ii. Whittington Hospital

The Whittington patient safety strategy is to work towards having no avoidable deaths and no avoidable patient harm. The Whittington is part of the Patient Safety First Campaign and through this has introduced several new ways to improve patient safety. Some of the patient safety initiatives at the Whittington are as follows:

- Review of the health records of every patient who dies at the Whittington to identify and act upon any lessons to be learnt to reduce risks for other patients;
- Weekly Patient Safety Walkabouts by senior managers, doctors and nurses;
- Introduction of the WHO Surgical Safety Checklist in theatres;
- Improved medicines management through ward pharmacists, introduction of new safer drug chart;
- Fall assessments on all older patients admitted to the Whittington;
- Aiming to screen all patients having surgery and all patients admitted to hospital for MRSA infection risk.

The Whittington has an extensive clinical audit programme, participating in national audits; national confidential enquiries and carrying out a wide range of locally generated clinical audits.

iii. Registration of the ICO with NHSLA and CQC

The Clinical Governance workstream is working with both the NHSLA and the Care Quality Commission to clarify what the requirements will be for assessment and registration of the ICO to reflect the merged services.

2.6.3 Improve patient experience

i. Alliance

The patient experience domain of the Alliance's Quality Improvement Work Plan tracks improvements delivered as part of:

- Learning from PALS contacts and complaints,
- Issues picked up from service-specific patient and public involvement work,
- Themes picked up from patient surveys, consultations and kiosk feedback,
- Intelligence from participation in local PPI forums, service user groups and links with community groups,
- Results from annual PEAT assessments and
- Progress on delivery of capital schemes.

The Patient Experience Group for Haringey is made up of staff across the Alliance and ensures that the Work Plan is delivered and that services meet patients' expectations and are responsive to their concerns. For Islington Services this is managed through the Directorate Management Teams Governance Committees with ongoing reporting around the workplan agenda, with additional focus on Patient Experience linked through CQUIN and other performance and quality measures, which are monitored via business meetings within services. The Alliance's services routinely score well

on key aspects of patient experience with satisfaction ratings typically around 85-90% for the three key questions on overall rating of care, involvement in treatment decisions, and treatment with dignity and respect.

ii. Whittington Hospital

The Whittington places a high value on the feedback received from patients. A number of different initiatives support the collection of both formal and informal feedback and make it easier to respond to patient enquiries, including:

- Regular patient surveys
- Learning from complaints
- Use of the 'Customer Focused Marketing Model' in which electronic kiosks and hand held screens have been rolled out to enable patients to give feedback more easily
- Use of user feedback to inform development of specific services, such as the midwifery-led Birthing Unit
- Focus groups with patients and carers,
- Integration of the admissions and appointments offices to form an Access Centre to make it easier to respond to patients enquiries

The feedback gained through these many different approaches is both fed back to services to act upon and used to identify themes for future improvement priorities.

A number of indicators known to impact significantly on patient experience are monitored regularly, such as:

- Ward cleanliness;
- Hospital cancellation rates for outpatient appointments;
- Provision of single sex accommodation;
- Patient involvement in decisions about care.

2.7 PROJECTED EFFICIENCY SAVINGS

2.7.1 Evidence from other organisations

Integrating care across the full patient pathway, from primary to community and acute care, presents a real opportunity to improve outcomes and reduce cost and therefore a mechanism to achieve clinical and financial sustainability. UK examples in Trafford and Hereford have modeled the potential impact of integrated care working across secondary and primary care and shown that there is the potential to reduce costs of up to 25%. Other examples from the USA also demonstrate the scale of the potential impact:

Geisinger used the 'medical home' approach (combined with revising payment mechanisms) to improve outcomes and cost management for patients with chronic diseases. With the medical home, primary care is organised around the relationship between patient and personal clinician. Twenty-four-hour access to care services (enhanced through the use of nurse care coordinators, proactive care management support segmented by categories of

need, and home-based monitoring), and patient and provider access to electronic health records. This resulted in a 20% reduction in hospital admissions and 7% savings in medical costs.

The Veterans Health Administration's Care Coordination Home Telehealth (CCHT) programme uses health informatics, home telehealth technologies, and patient self-management to provide chronic care management services to patients with six chronic conditions: diabetes, congestive heart failure, hypertension, post-traumatic stress disorder, chronic obstructive pulmonary disease, and depression. It has achieved 20% reduction in hospital admissions for chronic disease patients.

Kaiser Permanente's Collaborative Cardiac Care Service (CCCS) uses an integrated care approach (centered around multidisciplinary teams and an electronic patient registry) to improve rehabilitation and secondary prevention for post-acute cardiac patients. It has achieved improvements in quality of care (all-cause mortality reduced by 76% over eight years, patients at target cholesterol levels increased from 22% to 77%) and reductions in cost through fewer acute events (estimated to save $1,000 per enrollee per year, and a total of $3m across Kaiser per year)

The scale of the opportunity is therefore substantial. Translating this into local delivery will require us to focus attention on where integration can have the biggest gains – namely long-term conditions (~75% of healthcare spend), elderly care (high levels of fragmentation) and unplanned care. Whilst efficiency gains are essential, these will be delivered by taking a full approach to value and ensuring that at all times the interface with all aspects of quality is considered.

2.7.2 Required efficiencies

Ensuring the successful FT application of the integrated care organisation requires the generation of significant efficiencies over the next five year period. The base case as outlined in the financial modelling of the ICO assumes a 4% efficiency saving for community services, based on a 1.1% tariff efficiency plus 2.9% inflationary pressures. Should additional downside risks present as a consequence of, for example, commissioning intentions, these will be dealt with through decommissioning of services by the commissioner in advance of contract agreement as referenced in section 3.8.

It is recognised that the ICO will require higher levels of overall saving and this is a consequence of additional cost pressures for the acute trust over and above the standard tariff calculation. It is anticipated that by becoming an ICO, the organisation will have the ability to remove costs across the pathway as a whole. Efficiencies will be generated from a number of different work streams, which reflect both the integration of the Whittington Hospital services with Islington and Haringey community services and the continued emphasis on improving the efficiency of all services. Efficiency savings are a core component of the QIPP and CQUIN agendas. The following provide examples of identified areas where greater efficiencies can be made.

2.7.3 Transformation of new integrated ICO clinical services

The formation of the ICO will enable redesign of many pathways over the coming years. A number of pathways will be prioritised in year one where they offer the greatest efficiency gain or scope for improved clinical outcomes. The initial focus will be on the following areas:

<u>i. Reducing pathway fragmentation</u>

A number of pathways present an opportunity to reduce fragmentation for patients across primary, secondary and community services, e.g. older people's rehabilitation services, intermediate care, community matron in-reach and specialist rehabilitation services. Services will be organised

around the patient journey, rather than on existing organisational structures to speed up access at each stage of the pathway. Developing a 'team without walls' ethos, where specialists and generalists from secondary care, community and primary care, work together to deliver care closer to home. This workstream will build on current pathway work and translate existing concepts into delivery.

ii. Reducing duplication of services

Current duplication of services, e.g. reducing appointments and contacts that may be repeated in the community and in hospital due to a poor understanding of the patient's treatment plan and use of diagnostic tests. The use of one-stop shop services staffed by multi-professional teams can potentially help to reduce duplication of investigations and assessment.

iii. Keeping patients better for longer

Integrated care achieves best results when patients take control of their own health—when they actively manage their own care, avoid unhealthy behaviors, and can accurately identify when they need clinical intervention. Having patients take responsibility for their own care helps ensure that they do not inadvertently undermine the efforts of the integrated-care team. By building on the work of co-creating health, we will continue to support self management, and patient education. Combined with proactive care of patients in the community, this can achieve a reduction in the need for secondary care.

iv. Reducing length of stay

Reducing length of stay is a component of the CQUIN framework for supporting effective discharges within a hospital setting and also links with the national QIPP workstreams of back office efficiency and productive care. Service reconfigurations, which will have the greatest impact upon reducing hospital length of stay and reducing avoidable admissions, e.g. long term conditions. Reducing length of stay will enable a stepwise reduction in the bed base leading to some direct cost savings.

v. Impact of commissioning intentions, e.g. urgent care.

The implications of 2011-12 local commissioning intentions are being finalised.

2.7.4 Streamlining the organisation – non-clinical services

The integration and re-alignment of non-clinical services such as estates, finance, HR and ICT will provide an opportunity to generate economies of scale by moving from provision for three organisations down to one.

i. Review of models and levels of service provision;

A number of support service functions offer opportunities for economies of scale apart from the obvious examples listed above. Patient administration services such as those involved in referral and booking may benefit from scale and may offer extended hours of opening to support 8am - 8pm clinical services.

ii. Identification of further procurement savings;

There will be further economies of scale to be realised by moving to higher volume related purchases as the three organisations integrate into one. There are other opportunities for the community to benefit from the expertise of the Whittington's new procurement shared service to negotiate more robust and better value contracts for services and goods.

iii. Review of estate efficiency.

The Alliance operates out of large number of community sites with some services only running one or two clinics per week in some buildings. There is an opportunity to undertake a space utilisation review to identify which services and clinics could be centralised, and to review the estate service charges to those sites.

2.7.5 Reviewing the service provision models for significant other services not directly influenced upon by the creation of the ICO

Examples include:

- Theatres efficiency, including capacity, utilisation and throughput;
- Prison healthcare;
- Drugs usage and spend.

2.7.6 Requirement for all budgets to demonstrate an efficiency

As well as the savings that will be released from transformation of care pathways, all budgets will be required to identify a reduction in expenditure to mitigate against inflationary and tariff reduction cost pressures. Where efficiencies cannot be identified, the impact of the reduction will be described. Service line review will take place with a focus on levels of contribution in the context of service demand, commissioning and other sector providers

2.7.7 UCL Partners

UCL Partners are carrying out a number of workstreams across London to review possible areas for support services efficiencies. The Whittington is a member of UCLP and contributes toe the thinking and analysis of efficiency gains that may be made through the partnership approach. Projects are assessed locally for possible implementation and this will in future include the ICO.

2.8 GROWTH OPPORTUNITIES

Growth for the Integrated Care Organisation will stem from six sources:

i. Transfer of services to the ICO from other existing providers – usually following a tender process or from commissioning intention changes.

ii. Increasing market share for elective services through the provision of high quality, responsive services, which patients choose to use.

iii. Increased provision of non-NHS funded activities.

iv. Increased demand for services as a result of population factors

v. Increased provision of services already working across the sector e.g. audiology.

vi. Education – ensuring the ICO is the organisation of choice for clinical placements for doctors and Allied Health Professionals.

2.8.1 Transfer of services

The Integrated Care Organisation will assess the appropriateness of service transfer opportunities as they arise. A number of potential service transfers have been identified to date including Haringey Community Children's services.

2.8.2 Increasing market share

A number of services have shown significant growth in market share and the ICO will build on this through investment in capacity and maintenance of attractive waiting times where appropriate. There will a particular focus on:

- Maternity services
- Neonatal Intensive Care Unit services
- Day case surgery

In addition, the ICO will maintain and where possible further develop its education provision.

2.8.3 Non-NHS service growth

The Integrated Care Organisation will further explore the provision of services for private patients, seeing this as having a net benefit impact on NHS funded services. Initial consideration will be given to the following services:

- Maternity
- Day case surgery, with a focus on procedures which will no longer be funded through the NHS

2.8.4 Population Factors

Demand for many services continues to grow in response to population growth, changes in demographics and increasing deprivation. Responding to this demand, particularly for non-elective services, may lead to increased activity levels for some services. However, the integrated care organisation aims to respond to this demand through the realignment and more efficient provision of services.

2.9 DUE DILIGENCE AND FUNDING FORMULA

There are five work streams associated with due diligence as follows:

- Finance
- Estates & Facilities
- HR
- Clinical Governance
- IM&T

2.9.1 Finance

The Whittington is undertaking due diligence, both to understand the degree of clinical, operational and financial risk that faces the creation of the ICO, and also to inform the construction of the financial sum required by the ICO.

The outcomes from each of the work streams will provide a risk assessment of the governance and finances, which will wherever possible be offset by mitigating actions. To date the exercise has helped to inform the costing formula and will provide a baseline risk assessment.

The finance workstream represents a number of assessments upon community services along with a subsequent external review by KPMG. In addition, it includes a detailed bottom up costing for the financial sum required to adequately provide community services. It is recognised that savings are required as a result of tariff changes and the additional commissioning intentions of the PCTs and therefore it is important to ensure that these be both realistic and appropriately costed so as to not undermine the creation and future benefits of an ICO to offer efficiencies and value for money to commissioners.

2.9.2 Funding formula

The construction of the required contract value and the agreement of a viable contract sum require detailed working and a shared understanding of the services concerned. Consequently, it is relevant to describe the suggested framework for arriving at the contract sum required versus the contract offer and how any gap once known could be addressed. The figures below are intended to be illustrative in the absence of the completion of the due diligence and contract negotiations, and unless otherwise stated do not necessarily imply the likely forecast.

The agreed contract value will adhere to the following principles:

- Provides value for money and efficiencies to commissioners
- Be consistent with NHS planning assumptions e.g. efficiency and cost pressures
- Deliver a contract sum that is fair and realistic and consistent with the creation of a viable ICO and its eventual approval as an FT
- Further savings that are required by the commissioner are delivered by decommissioning and that subsequent severance costs are planned for and met by commissioners prior to contract signing.

There are numerous areas where recharges exist between the community services and either the commissioners or other bodies. Examples will include estates and facilities, IM&T, financial ledgers and audit charges. In the absence of, and until, detailed financial costings suggest to the contrary it is proposed that these recharges are treated as a pass through costs for the duration of the contract. This effectively means that any inaccuracy in the current provider recharge is under-written by the commissioner. With regards to cash flow, it is a requirement that the contract sum is paid regularly each month, without a build up of arrears.

The potential risk associated with outstanding creditors and debtors is significant. The Trust would require that the closing 2010/11 creditors/debtors requires an indemnity from IPCT and HPCT for non-collection/inadequate provision, should actual collection/payment values differ from that allowed for within the 2010/11 accounts. A time limit of the first financial year would be needed for determining adequacy.

The alternative and preferred approach of the Trust, is that the closing debtor and creditor values do not transfer to the ICO and that all 10/11 related invoices are paid by the commissioners along with receiving any cash collected from the 10//11 debtors. The one exception associated with this

approach applies to the annual leave creditor which needs validation and either transfer or incorporation as a non-recurrent value in the first years SLAs. The choice around how debtors and creditors are to be treated, will be influenced by NHS London and DoH rules for accounting for Community services transactions.

The financial funding formula works on the principle community services will deliver a 4% efficiency saving resulting from a 1.1% tariff reduction and a 2.9% inflationary cost pressures e.g. resulting from pay and non-pay and national insurance increases. Additional reductions in income over and above this level would be expected to result from decommissioning decisions outlined in commissioning intentions.

Contact sum required by ICO for community services	£m (Illustrative)
Forecast actual expenditure of current 2010/11 services established through bottom up DD work	93.0
Less forecast actual income from sources other than NHS Islington and NHS Haringey established through bottom up due diligence work	(28.0)
Forecast net expenditure in 2010/11	**65.0**
Adjustments going forward into 2011/12	
+/- non-recurrent savings/pressures in 10/11 e.g. vacancies & prior year invoices	2.0
+/- Full year effect of agreed and deliverable savings/pressures in 10/11	(1.0)
+ Cost pressures for community services including pay & non pay inflation/increments/NI increase as per NHS guidelines re efficiency and tariff assumptions – 2.9% increase	2.0
- efficiency assumption as per NHS London guidelines – 4% reduction	(2.6)
+/- changes in recharges for a range of clinical & non clinical services from all sources	2.0
- Services that are not to transfer e.g. smoking cessation & Hanley rd	(5.0)
+ Not transferable/ saveable costs associated with non-transferring services	0.5
+ Non recurrent costs that are not provided for in the 10/11 commissioner a/c's, particularly in relation to severance for planned de-commissioning decisions	3.0
- net releasable savings from planned and agreed de-commissioning, e.g. GreenTrees, decisions	(1.0)
+/- changes in funding levels from sources other than Islington & Haringey PCTs	1.0
+/- changes in costs from changes in funding levels from sources other than Islington and Haringey PCTs	0
Sum required from Islington & Haringey PCTs in 2011/12 to meet initial commissioner requirements	**65.9**
- further de-commissioning savings plans	(5.0)
+ further provision for non-recurrent costs	2.0
Final 2011/12 SLA for community services excluding other income sources	**62.9**

The table below looks at the same framework, but this time from the commissioner perspective.

SLA offer for the ICO for community services from all commissioners and income sources	£m (Illustrative)
Agreed 2010/11 SLAs and funding agreements – all sources	94.0
Less agreed income SLAs from sources other than NHS Islington and NHS Haringey in 2010/11	(29.0)
Baseline funding levels for Islington and Haringey in 2010/11	**65.0**
Adjustments going forward into 2011/12	
+/- variable element of community services SLA reflect realistic 11/12 activity levels	1.0
- services that are not be commissioned via the ICO e.g. Smoking and Hanley rd	(5.0)
+/- Effect of de-commissioning and savings initiatives that were agreed in 10/11	(2.0)
Sub total 2011/12	59.0
- Implied tariff reduction as per NHS London guidelines – 1.1%	(0.6)
+ Non recurrent costs that were not provided for in the 10/11 PCT accounts	3.0
- net releasable savings from planned and agreed de-commissioning decisions in 11/12	(2.0)
Sub total before further de-commissioning and further severance costs	59.4
- decommissioning plans required to balance to NHS Haringey & Islington PCT affordability	(5.0)
+ additional severance provision required	2.0
+ adjustment to 11/12 SLA to reflect a) inability to match income reductions with expenditure savings b) cost pressures not funded c) non-recurrent savings d) underwrite pass through costs	6.5
Final 2011/12 SLA for community services excluding other income sources	**62.9**

These two presentations are intended to represent an approach to how a gap is resolved between the prospective ICO and the commissioners in relation to the sum required for community services. The intention is to on the one hand, recognise PCT affordability with on the other hand a realistic assessment of costs/savings plans, non Haringey/Islington funding, combined with an efficiency assumption that community services needs to find. The gap is ultimately resolved by de-commissioning with any severance costs being reflected as part of the funding quantum.

2.9.2 Estates and Facilities Due Diligence

Estates and Premises Management

The ICO will provide services from over 70 centres in Haringey and Islington. No assets will transfer to the ICO in the short term. Both Islington and Haringey PCTs will retain ownership of premises, and will act as head leaseholder where services are provided from local authority or

private property owners. The PCTs will continue to provide hard and soft services to the ICO as tenant and these services will be set out in a SLA. Rent, utility, and service charges will be a pass through cost. All leases will be in place from April 2011 and the PCT will indemnify the ICO for changes to commissioner intentions and changes to the provisions on any leases.

Hard and Soft Service Provision

Under a tenancy agreement, which will include appropriate break clauses all premises management services will be covered by a SLA between the PCT as landlord and the ICO as tenant. Following a full Condition Survey and Due Diligence Audit of Compliance the PCT will review any compliance issues before the service commencement, and suggest an approach with the ICO to the longer term achievement of compliance.

Medical Equipment

Medical Equipment assets will transfer to the ICO. A full asset register of all medical equipment will be provided by the PCTs, The asset register will provide purchase date, life of asset and details of lifecycle maintenance, including service contracts associated with each piece of equipment. Any current SLA, and full costs associated with delivery of the service will be provided to the ICO in advance of service commencement.

Due diligence is also underway in the following areas:

- Procurement
- Decontamination
- Health & Safety

The scope of the services and the costs associated with these is subject to checking under the due diligence process. At this stage it is proposed that until the risks and costs are fully identified and understood, costs will remain a pass through between the PCTs and ICO.

2.9.3 KPMG review of the ICO

Attached at appendix 2 is an extract of the ICO standalone financial projections. In summary the base case and down side case after mitigations confirm a financial risk rating of four from 2012/13 onwards subject to a number of assumptions.

3. LOCAL CONTEXT

3.1 CONTEXT

This business case sets out the intention to form a new Integrated Care Organisation (ICO) from The Whittington Hospital NHS Trust and the Haringey and Islington Provider Services APOs, currently operating as an Alliance. The drivers for change and benefits for local people and the local health economy are examined, alongside the drivers for efficiency gains. An overview of the post merger plans are described setting out how the new organisation will operate.

During 2009, NHS Haringey and NHS Islington Boards entered into a strategic partnership to establish and develop the community services Alliance across both Boroughs as their initial phase of provider development for implementing the Transformation of Community Services policy. This followed a year of joint collaboration to strengthen the senior leadership of directly provided adult community services for NHS Haringey. The Alliance has a Joint Board and Management Team that operates within a robust scheme of delegated governance responsibilities.

3.2 NATIONAL POLICY AND LOCAL STRATEGY

National policy dictates that Primary Care Trusts should divest themselves of their provider services by April 2011. This divestment creates a clear separation between commissioning and provider functions, ensuring providers become business ready and provide high quality services in an environment of choice and contestability. Local guidance suggests that community providers align themselves along care pathways and with the preferred option of vertical integration with local acute secondary care providers

The coalition government's programme gives a clear steer that NHS services should make inroads to increase efficiency savings, reduce waste, and collaborate better between different parts of the public sector, particularly with local authorities. The size of the efficiency savings required across the NHS and North Central London sector in particular, require significant changes in the way services are delivered to reduce cost; this cannot be achieved through the usual annual cost improvement programmes.

3.3 OPTIONS CONSIDERED AND PREFERRED OPTION

3.3.1 Criteria for option appraisal

The PCT Boards' criteria for option appraisal were developed initially through two staff engagement events in July 2009, involving about 200 staff, engagement with community partners, and Joint Provider Board and Alliance development workshops. These criteria were presented to September PCT Board meetings and updated at both November Public PCT Board meetings, as follows.

In summary, the proposed criteria were:

a) Readiness and capability to transform services:

- High Quality Patient Care – focused on safety, safeguarding, satisfaction and improving outcomes for all
- Best Value for Money – delivered by increasingly integrated, innovative, preventative and productive health and social care services
- Employer of First Choice for staff - who feel well motivated, trained and supported as valued care team members
- Strategic Fit – with local PCTs, Local Area Agreements and national health and social care Vital Signs priorities and Care Quality Commission standards
- Transformational and commercially competitive organisation – with a sustainable portfolio of developing services focused on communities' health needs

b) Strength of Leadership

c) Feasibility within the available resources in the context of London and Sector Financial Planning Assumptions

The Joint Provider Board also developed an advisory Task Group with staff and patient representation, and updated the criteria to take into account the NHS Operating Framework and emerging guidance from NHS London.

In February 2010, the Joint Chief Operating Officer updated and validated the criteria against:

- The publication of the Department of Health's latest Transforming Community Services Guidance setting out the three Tests of Quality Improvement, Increased Efficiency and Sustainability, with specific criteria
- NHS London's assurance process, revised to accommodate the above
- The cross-sector review of PCTs' criteria, led by the Chief Executive of NHS Barnet

These criteria were then used by the Joint Provider Board Task Group to seek feedback on and evaluate the feasible options.

3.3.2 Option Identification

At the NHS Haringey and NHS Islington Board meetings in November 2009 and January 2010, the Boards set the decision making framework and criteria for identifying, developing and evaluating feasible options and determining the future organisational form for the Alliance. All options were

expected to build on the integrity of the Alliance as a provider of integrated community health services across both Haringey and Islington, excluding Haringey's Children's Services commissioned from Great Ormond Street Hospital.

An "open door" policy was operated through sustaining an on-going dialogue with all local strategic partners and responding to any direct approaches to the Alliance to explore potential organisational options.

Option identification was guided by staff and community partner engagement and the development of the Alliance's strategic direction by the Joint Provider Board. Equally important was been the direction given by both PCT Chief Executives, for the Alliance to focus on developing and testing an option based on vertical integration with the Whittington Hospital. This was undertaken in the context of PCT Commissioning Strategy Plans, strong support for this model in the December 2009 Department of Health Operating Framework and from the Sector Task Group on Integrated Care Organisational options.

PCT Boards tasked the Alliance Joint Provider Board to apply the criteria to evaluate this option against other feasible options to establish whether the option achieves a significantly greater balance of quality, efficiency and sustainability benefits for patients through improved care pathways with GP and Local Authority partners.

At the February 2010 staff engagement events, staff were presented with the opportunity to re-consider the outcomes of the July 2009 workshops, which did not support employment in social enterprise, general practice, private sector or local government organisations. Staff confirmed their views about these options had not changed, whilst emphasising the importance to staff and patients of continuing to work together in effective partnership with these organisations.

3.3.3 Feasible Options

The following were therefore identified as the feasible options for evaluation by the Task Group to advise the Joint Provider Board:

- A new integrated organisation:
  - Formed together with the Whittington Hospital (as a FT application)

- An existing FT, within North Central London Sector:
  - Camden and Islington Mental Health FT
  - UCLH FT, potentially with other hospital trust/s

- Other likely FT applications within NCL Sector:
  - North Middlesex Hospital, potentially with other hospital trust
  - BEH Mental Health Trust, potentially with other community partners

- Outside NCL Sector:
  - Central London Community Healthcare (applying to become London's only Community FT)
  - Other interested potential providers

<u>The Whittington Hospital</u>

Of these, the Whittington Hospital established contact and expressed a strong interest in exploring both service and organisational synergies in July 2009. This was progressed through the Search for Synergy workshops with acute and community clinical leaders and GPs, to identify support

service efficiencies and the joint response to NHS Islington regarding the Urgent Care Centre development. At recent meetings at Chair and Chief Executive/Chief Operating level, the Joint Provider Board's guiding principles were discussed and a Statement of Intent was drafted for presentation to and feedback from both the Joint Provider Board and the Whittington Hospital Board March 2010 meetings. This was reviewed, strongly welcomed and supported by Joint Board members as offering the firm foundations from which a new, integrated organisation could be built.

North Middlesex Hospital

Informal discussions took place in February 2010 with the North Middlesex Hospital's Chief Executive. North Middlesex Hospital had expressed interest in NHS Enfield provider services and was interested to discuss the community services provided by the Alliance to East Haringey. The Chief Operating Officer explained the Joint Provider Board's guiding principles, including the integrity of the Alliance's commitment to serving all of Haringey and Islington. On 16 March 2010, the Chief Executive of North Middlesex Hospital wrote to the Deputy Chief Executive of NHS Haringey setting out the Trust's interest.

Camden and Islington Mental Health Foundation Trust

Informal discussions took place in February 2010 with Camden and Islington Mental Health Foundation Trust's Chair and Chief Executive, who were interested to discuss the potential community services synergies between mental health and community health services, in particular with social care. The Chair and Chief Operating Officer explained the Joint Provider Board's guiding principles, including the integrity of the Alliance's commitment to serving all of Haringey and Islington and engaging with acute and GP partners. On 12 March 2010, the Chairman of Camden and Islington Mental Health Foundation Trust wrote to the Chairs of NHS Islington and NHS Haringey setting out the Trust's interest.

Central London Community Health

A further option was identified following a meeting in mid-February 2010 between NHS Haringey and NHS London, which included a discussion regarding future organisational form. Central London Community Health (serving Kensington and Chelsea, Westminster and Hammersmith and Fulham PCTs and Boroughs) has secured Department of Health approval as a viable provider to consult on and apply for authorisation as one of the applicant Community Foundation Trusts expected to be assessed by Monitor.

3.3.4 Joint Provider Board decision

At the meeting on 10 March 2010, Joint Provider Board members discussed in depth the various partner options, considering how each would help deliver the stated vision and strategic objectives.

Joint Provider Board members considered that:

- The organisation should be local and share a strong sense of community spirit
- They saw it as their leadership role to ensure that a new locally based and focused organisation fully owned and incorporated neighbourhood public health inequalities and outcome improvement priorities in every polysystem across both Boroughs
- There was a high risk of loss of focus on transforming community services in acute organisations facing large scale and/or highly complex mergers over relatively long timescales
- There was an equivalent high risk of loss of focus and conflicting decision making priorities in organisations with complex governance arrangements across large and politically diverse geographical areas across London

- Every organisational option and poly-systems map brings with it major boundary issues that will require consistent care pathways to provide the frameworks for informing and supporting patient and clinician choices
- Every organisational option brings significant financial risks both due to shared the Sector Service and Organisational Review economic scenarios and risk of different organisational strategies for addressing budget pressures on the community services portfolio.

The Joint Provider Board decided that only one option was capable of achieving a significantly greater balance of quality, efficiency and sustainability benefits for patients through poly-system care pathways with GP and Local Authority partners. This option was the formation of a new, integrated, local NHS organisation, which combines the Alliance's community services across the Boroughs of both Haringey and Islington with the Whittington Hospital's acute services.

The main rationale for this is summarised below:

- Local option with best geographical fit to shared care pathways
- Strongest alignment of local and NCL sector service and organisational incentives to change to safely manage most care more locally
- Realistic organisational balance between community (~£100m) and acute (~£150m) portfolios in the context of managing the impact of the acute to primary care shift
- New organisation and culture set up to respond to Commissioners priorities for community needs as the foundation for partnerships in every neighbourhood across both Boroughs
- Option most capable of combining existing service based funding with population based funding to incentivise preventative care

The Joint Provider Board considered that a contingency plan is required for this preferred option, due to the uncertain medium-term organisational landscape for acute services associated with the stage reached in the Sector Service and Organisational Review and rigorous NHS London Assurance and Monitor FT Authorisation processes. It was agreed that this should be based on an Expression of Interest process to be initiated if the preferred option became un-viable.

3.3.5 NHS Haringey Board and NHS Islington board decisions

The Alliance Joint Provider Board members from both PCTs strongly supported the formation of a new integrated care organisation (ICO) which combined the Alliance's community services with the Whittington Hospital's services. NHS Islington Board members expressed support for the Joint Provider Board recommendations for an ICO with The Whittington. However, concern was expressed by NHS Haringey Board members that other options had not been sufficiently explored and that the potential benefits of the Whittington hospital proposal had not been spelled out fully.

As a result, the timetable for decision making was revised to include an Expression of Interest process to be completed by April 2010. Expressions of Interest invitations were sent to local organisations on 29 March 2010; four organisation were shortlisted and presentations given on 16th April. On 22nd April 2010, a sub group of the NHS Haringey Board met to make the final decision regarding a preferred provider and The Whittington Hospital was selected as the preferred provider for Haringey Community Services.

3.3.6 Assurances for East Haringey and the North Middlesex Hospital

During the consultation period for the ICO concern was expressed in particular that the creation of the new organisation might compromise the rights of GPs and patients in the East of Haringey in particular. A series of meetings have been held with GP stakeholders to discuss this issue and reassurances given. In addition to this as part of the process of setting up the ICO, the Whittington Hospital has agreed to a range of assurances around patient information and Choose and Book, which mitigates any such concerns e.g.

- The merged organisation will comply with the Primary Care Trusts Directions 2009 and NHS Constitution which enshrines the right of a patient to choose his/her provider of elective acute case.
- The ICO will implement Choose and Book effectively.
- The referred patient will receive a letter which will:
- Inform them of their right to choose their hospital of treatment
- Inform the patient they do not have to choose the Whittington Hospital
- Inform the patient of the NHS Choices website
- Offer assistance under Choose and Book.
- Staff will receive training on NHS Choices and how to use the Choose and Book system and records of training maintained.
- In the event of any suspected breaches, the Co-Operation and Competition Panel (CCP) will investigate and the ICO will comply with any written directions from NHS London, NHS Islington and NHS Haringey.
- The ICO will co-operate fully with the CCP and NHS London to monitor compliance.

The ICO will engage with GP practices through a wide range of fora including individual practice meetings to discuss issues and give these assurances. The ongoing relationship and dialogue that exists between the Alliance and the North Middlesex will continue following the creation of the ICO.

3.4 SERVICES TO BE TRANSFERRED

Commissioning intentions detailed in section 3.10 describe how some of the services below may be subject to change.

3.4.1 List of services currently provided by NHS Haringey Community Services

<u>Adult services:</u>

- Audiology Service
- Nutrition and Dietetics Services
- Community Dentistry in Haringey and Enfield
- Outpatient Physiotherapy
- Foot Health
- Wheelchair Services
- Community Speech & Language Therapy
- Sexual Health

- Contraceptive Services
- Adult Psychological Therapies
- Primary Care Mental Health
- Continence Advisory Service
- Community Nursing (including District Nursing, Community Matrons and specialist nursing teams for HIV, lymphoedema, tissue viability, diabetes and palliative care)
- Integrated Care Therapy Services
- Greentrees Rehabilitation Unit (inpatient)
- Learning Disabilities Service – provision of nursing staff to LB of Haringey managed service
- Practice Nurse Development
- Expert Patient Programme
- Safeguarding Adults
- Working for Health Programme
- Physiotherapy Services for Camden & Islington Mental Health & Social Care Trust
- Physiotherapy Services for Barnet, Enfield and Haringey Mental Health Trust
- Dietetics Services for Barnet, Enfield and Haringey Mental Health Trust
- HR (Haringey and Islington)
- Occupational health

Support services:

- Human resources
- Provider finance
- Business Development Team

A short description of each service is included in **Appendix 1**

3.4.2. List of services currently provided by NHS Islington Community Services

Adult services:

- Bladder & Bowel service (Islington, Camden, and CIFT)
- Continuing Care
- Community Matron Service
- Community Rehabilitation Team (integrated service with LBI)
- Community Dental Services (Islington & Camden)
- Community Diabetes Specialist Nurse Team
- Nutrition and Dietetics (Islington, Camden and CIFT)
- District Nursing Services
- Expert Patients Programme
- Heart Failure Specialist Nurse Team
- ICES – Integrated Community Equipment Service with LBI
- Lymphoedema
- Musculoskeletal (MSK) Triage Service
- Pentonville Prison healthcare service as lead provider within consortium
- Podiatry
- Physiotherapy
- Practice Nursing
- Primary Care Alcohol and Drugs Service
- Primary Care Mental Health Team (IAPT)
- REACH Intermediate Care (Integrated with LBI)
- Respiratory Specialist Team (COPD)
- Sickle Cell & Thalassaemia Service (Islington and Camden)

- Smoking Cessation (Islington – likely from April 2011)
- Substance Misuse Service
- Tissue Viability Service (Islington, Camden and CIFT)

Children's Services:

- Audiology Service - Universal
- Child and Adolescent Mental Health Services - Specialist
- Community Nursing Services- Targeted
- Child Protection Service - Universal
- Family Nurse Partnership Programme
- Health Visiting & School Health Service - Universal
- Islington Specialist Children's Service (ISCS)
- Occupational Therapy Service - Targeted
- Paediatrics Team - Specialist
- Physiotherapy Service - Targeted
- Simmons House, Adolescent Psychiatric Inpatient Unit
- Speech and Language Therapy Service – Targeted (Islington & Camden)

Support services:

- Human resources
- Provider finance
- Business Development & Information Team
- Health centres administration team
- Administration and Referral Team (formed from RiO systems admin, Central Booking Team and Child Health Information teams)
- Quality and Clinical Governance (inc. PALS and Complaints)

3.5 SERVICES NOT TRANSFERRING INTO THE ICO

Both PCTs reserve the right to initiate in year Commissioning changes, giving due notice in line with current NHS commissioning practice. In order for the ICO to plan on a robust basis, it will be necessary to indicate the likely commissioning decisions for each of the three contract years. In addition, as FT applications require a five-year plan, a further two years require detailing as commissioner support and confirmation is a pre-requisite for a feasible FT application by the ICO.

NHS Haringey commissioners retendered Smoking Cessation services across Haringey and Enfield in September 2010 and Haringey Community Services were not successful in retaining the contract. Staff from this service will TUPE into Innovision, who won the tender, in January 2011. Additionally, North Middlesex University Hospital served notice on the Acute Therapies Service contract provided by Haringey Community Services and these staff will TUPE into the North Middlesex Hospital in December 2010.

Hanley Primary Care Centre (GMS practice) and the Islington Primary Care Service (SPMS for substance misuse & homeless) are not transferring as part of the community contract as advised by the Co-Operation and Competition Panel (CCP) under the fast track application. These two services will be subject to further review by the CCP over the coming months and may need additional assurances from the ICO around issues of patient choice for secondary care onward referral.

3.6 STAFF TRANSFERRING

In total 1,935 staff equivalent to 1,575 WTE will be transferred to The Whittington NHS Trust subject to final confirmation from the TUPE Transfer document.

Islington Community Services staffing:
Headcount (approximate): 1,120
W.T.E. (approximate): 890

Haringey Community Services staffing:
Headcount (approximate): 815
W.T.E. (approximate): 685

3.7 TRANSFER OF ASSETS

At present, it is assumed that only a limited number of assets will be transferred, and that the estate will continue to be owned by the PCT. If further assets are to transfer, guidance will need to be sought from NHS London as to whether the transaction will constitute a divestment or not. If there is a transfer of assets, the host commissioners will need to consider the implications for the future procurement or commissioning of the relevant services. This position will be reviewed in light of the new DoH guidance and the ability of the ICO to hold the full range of property assets. In the short term, at least, it is proposed that property costs are treated as a pass through cost until more is known by the ICO.

3.7.1. Assets to transfer

It is assumed that the only assets transferring from Community Services will be the limited number, which are currently minimal and mainly relate to IT or clinical equipment.

3.7.2 Assets not transferring

A comprehensive list of all the estate owned by the PCTs will be included within the agreement for Estate and Facilities with the detail of any Capital Charge owing to the PCT. This will include a summary of owned and leased property and land, basis of valuation, depreciation rates, profit/losses on disposals, any fixed assets held under finance leases, nature of any intangible assets, surplus assets identification, valuation and future strategy.

3.8 VALUE AND LENGTH OF CONTRACTS

The Whittington Hospital NHS Trust is currently commissioned through the standard DH Acute Contract which operates mainly on payment by results (PbR) funding. The Alliance is currently commissioned through the Community Contract, which is generally block funded irrespective of in-year activity. It is proposed that the ICO continues to be commissioned through these two separate standard contracts but with a single host arrangement for Haringey and Islington commissioners. The Heads of Terms relating to the transfer state that the initial contract will be for three years subject to normal commissioning arrangements. Both PCTs however reserve the right to initiate in year Commissioning changes, giving due notice in line with current NHS commissioning practice. It is important that all commissioning changes are planned well in advance of the community services transfer contract sign off, for example, if severance costs are to be minimised, as sudden unexpected material changes will affect the financial viability of the ICO and may affect the ability of the ICO to provide the appropriate level and quality of service

In order to demonstrate our commitment to delivering the benefits of integrated care, in particular reducing the dependence on acute services for patients with long term conditions, a move towards a different contract model for long term conditions will be welcomed. This will ensure that financial incentives support the direction of travel.

Whilst it is recognised that substantial commissioner savings are required, it is important to distinguish between that element that can realistically be delivered through efficiency and that which requires an acceptance around levels/range of services provided. Commissioners should be assured that current DoH efficiency assumptions modelled for the community services mirror those for NHS trusts and this is what has been assumed in the funding formula described in this business case and the current Whittington's FT long term financial model. Specifically, that in order to fund a 1.1% drop in the national tariff prices and a 2.9% expenditure pressure, a 4% efficiency requirement exists on the ICO expenditure budget. Should a larger than 1.1% value be agreed through efficiency, the actual rate of savings required by community services translates to an even greater sum, as the ICO would also need to absorb the expenditure pressures.

The funding formula is detailed in section 3.8 and sets out the suggested approach to ensuring that the contract income matches the running costs of the transferred community services. Any gap identified over and above the standard efficiency assumptions will be addressed through contract negotiations and this may include decommissioning of services prior to contract sign off. Any savings delivered through decommissioning over the period of the contract the commissioner will receive savings net of severance costs.

3.8.1 Haringey contract value

Contract discussions as of the last week of October, are at an early stage of development. Commissioners have signalled a contract offer for 2011-12 ranging from a best case scenario of a 4% reduction on the 10/11 baseline, equating to around £900k. This is based upon the latest NHSL planning assumptions regarding efficiency. The worst case is likely to be an additional reduction of 10%, equating to £2.2m and £3.1m in total. A number of decommissioning options are being reviewed between the Alliance and Commissioners to identify the impact of a larger 10% reduction. Clarity is also needed on how the early management cost reduction will be treated and whether it is included within the 4% efficiency savings.

The following table shows the value of the proposed savings and additional cost pressures through pay and non-pay inflation:

Haringey Contract Value 2010/11	22,775
Less	
Decommissioned Smoking Cessation Contract	680
Opening baseline for Haringey Contract	22,095
Less	
Efficiency assumptions as per NHS London at 4%	885
Decommissioning Intentions at 10%	2,210
Haringey 2011/12 Contract Value	£19,000
Plus there could be the addition of the following	
Outstanding PCT Management Cost Target	460k
Pay and Non Pay Inflation at 2.9%	641k
Total cost pressures before effect of any Decommissioning	£4,196k

3.8.2 Islington contract value

Islington commissioning intentions for 2011-12 suggest a reduction in income of around 7% (£2.8m) excluding the recurrent 2010-11 surplus of £1.3m, or a 10% (£4.1m) reduction if the surplus is included. This would give a contract value of around £36.2m in 2011-12 against a 2010-11 value of £40.3m. All of these figures exclude the CQUIN income, which is forecast to be around £458k in 2010-11.

Islington Contract Value 2010/11	40,830
Less	
Non Recurrent CQUIN funding 2010/11	458
Opening baseline for Islington Contract	40,372
Less	
Adult Services	1,278
Children's Services	917
Reduction in Surplus	1,300
Recurrent 2010/11 Efficiency Target	600
Non Recurrent Items	32
Total 2011/12 Proposed Contract	£36,245k
Plus there could be the addition of the following	
Outstanding PCT Management Cost Target – but the Commissioners have already identified some management savings above	1,100k

Within 3.8.1, there is an illustrative table of what the total could be for the combined Alliance. The cost pressures below are before the completion of the due diligence process and highlight the underlying cost pressures for the Islington Contract. Islington Provider services have over £18 million pounds of contracts outside of the NHS Islington contract that have not yet confirmed the 2011/12 position. The generic cost pressures identified in the table will also be applicable to other contracts. The intent behind the savings planned against Adult and Children's services may well be replicated when other contracts are finalised.

Identified savings proposed within Contract	
Adult Services	1,278
Children's Services	917
Cost pressures for community services including Pay & Non Pay inflation/ Pay Increments/ National Insurance Increase as per NHS guidelines re efficiency and tariff assumptions – 2.9% increase	1,170
Management Cost target – full value but some may be identified above	1,100
Total Cost Pressures within Islington contract	£4,465k

3.8.3 Islington Community Services contracts

In common with most PCT community providers, the majority of the income is derived from the host commissioner, NHS Islington (69%), chiefly through the standard DH Community Contract although there is significant funding from London Borough of Islington and Camden PCT.

Total income for Islington Provider Services is projected to be £55.6m in 2010/11. Of this, £40.9m is derived from Islington PCT as the host commissioner. A further £7.9m is derived from other PCT contracts along with £2.5m from the London Borough of Islington (LBI) and the remainder from a variety of other sources. The provider arm is heavily dependent upon its host commissioner for income.

The standard DH community contract on a block funding basis is used for the majority of services, although Simmons House (tier 4 inpatient CAMHS), district nursing, physiotherapy, MSK and community matrons are funded on a cost and volume basis with a set unit price based on face to face contacts. The latter four services over-performed in 2009-10 by around £300k.

Community Dental Services are commissioned on a new 3-year Personal Dental Services (PDS) contract starting in 2010-11 also on a block basis. Other contracts include Hanley Primary Care Centre, a salaried GP practice, run as a PCT Medical Services (PCT MS) contract. A further GP-led service is provided by the Islington Primary Care Centre, which looks after substance misuse patients and homeless people who are not registered elsewhere. This service operates under a Specialist Provider Medical Services (SPMS) contract.

Islington Provider Services operates in two consortia contracts, the first an Alternative Provider Medical Services (APMS) with Camden and Islington Foundation Trust (C&IFT), and Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) to provide health services into Pentonville prison. IPS delivers the primary care element of the service. BEHMHT delivers forensic mental health and C&IFT substance misuse and inpatient mental health. IPS holds the APMS contract with NHS Islington and subcontracts to BEHMHT and C&IFT.

The second consortium contract is for a substance misuse service (ISIS) where IPS is subcontracted through an APMS contract with Cranstoun, a voluntary sector organisation to provide an opiate prescribing service with nursing support.

The largest risk of the above contracts lie with the cost and volume nature of the Simmons House SLA where operating costs are around £2.2m annually and a bed occupancy rate of around 85% is required to break even. In 2009-10, Simmons House made a small loss; however, since the opening of a new purpose built £4m unit in late 2009, bed occupancy levels have much improved with referrals from a much wider range of commissioners. It is envisaged that improved rehabilitation care pathways developed within the ICO will raise bed occupancy and provide opportunities to reduce length of stay and costs in the acute setting thereby mitigating this risk for the ICO.

Host PCT – Islington Block	40,830
NHSI Non Block Contract Income	1,742
NHS Foundation Trust	345
Other PCTs	9,177
Local Authorities	3,652
NHS Trusts	907
London SHA	1,283
Non NHS	1,482
Total income	£59,418k

NHS Islington Provider Services income 2010-11

3.8.4 Haringey Community Services contracts

As is the case with Islington, the majority of the income is derived from the host commissioner, NHS Haringey, primarily through the standard DH Community Contract although there is significant funding from London Borough of Haringey, NHS Enfield and the North Middlesex Hospital.

Total income for Haringey Provider Services is projected to be £37m in 2010/11. Of this, £24.7m comes from Haringey PCT as the host commissioner. A further £5.5m is derived from other PCT contracts along with £2.5m from the London Borough of Haringey (LBH) and the remainder from a variety of sources. The provider arm is heavily dependent upon its host commissioner for income.

The standard community contract is used for the majority of services and nearly all income is agreed on a block contract basis. For a significant number of services, activity is monitored and variances against last year's out-turn are reported and discussed at regular performance review meetings with Commissioners. As yet, there are no contracts that have been agreed on a cost and volume basis, although GUM services are purchased at out-turn under a PbR tariff.

Dental Services are commissioned in line with the new Personal Dental Services (PDS) contract that was introduced in 2010-11. Other contracts include a number of smaller contracts that support the provision of therapy services to BEHMHT and LBH, as well as a range of training and development activities.

Host PCT - Haringey	22,979
Host PCT Tariff (estimate)	1,818
NHS Foundation Trust	9
Other PCTs	5,334
Local Authorities	2,160
NHS Trusts	3,701
London SHA	377
Non NHS	257
Total income	£36,635k

NHS Haringey Provider Services income 2010-11

3.8.5 Transfer agreement

To be finalised and added at Appendix 3

3.9 PROPOSED TRANSACTION DATE

The ICO Programme Board has signaled that the transfer of staff and contracts from Haringey and Islington Community Services into the Whittington Hospital NHS Trust will take place on 31st March 2011.

3.10 COMMISSIONING INTENTIONS AND PROJECTED CONTESTABILITY OF CONTRACTS

The future contestability of existing community services will depend upon the commissioning intentions of NHS Haringey and NHS Islington for 2011-12 and beyond, the North Central London (NCL) Sector Commissioning plans and the emerging local GP Consortia's' priorities. The NCL sector will coordinate a single QIPP strategy for its constituent PCTs in 2011/12 planning up until 2014/15 in line with the Treasury's Spending Review. The Barnet Enfield and Haringey Clinical Strategy is also currently under review against the four tests from the White Paper *Equity and Excellence: Liberating the NHS* and the outcome of this may influence the commissioning intentions for the ICO.

These commissioning intentions are part of a wider and longer term strategic context resulting from the White Paper *Equity and Excellence: Liberating the NHS, which* sets out the ongoing commitment to the existing QIPP Initiative.

The following sections outline the commissioning intentions by Commissioner. These will be given due regard with a view to delivering the wider financial and clinical benefits to our community. However, they will be subject to the contract negotiation process for the ICO.

3.10.1 North Central London Sector Commissioning Intentions

To be confirmed

3.10.2 NHS Haringey Commissioning Intentions

The NHS Haringey Strategic Commissioning Intentions to deliver Quality, Innovation, Productivity and Prevention (QIPP) - 2011/12 set out commissioning changes for the coming year and sits alongside the existing NHS Haringey Strategic Plan 2009-14 *Long, happy, healthy lives in Haringey.* This latter document supports the implementation of the QIPP approach in local strategic planning covering five strategic goals:

1. Safe, healthy starts for all children and young people (C&YP)
2. Good mental health well-being for all
3. Prevention and management of long term conditions in adults
4. Healthy communities
5. Going local – care closer to home

Commissioning intentions for 2011-12 centre on the following core areas for community services:

<u>Rehabilitation and intermediate care</u>

A proposal will be requested for a model of Rehabilitation and Intermediate care for people with long term conditions including stroke rehabilitation in Haringey developed through service redesign of the following schedules from the provider contract:

- Greentrees
- ICTT
- Wheelchair service
- Respiratory services
- Community nursing – including community matron assistants
- Foot health and dietetics

It is unclear whether this would represent an overall reduction in provider income or a reconfiguration of existing services into new pathways.

Virtual wards

This will include development of admission avoidance and intermediate care services in partnership with the Local Authority using a virtual ward model for targeted long term condition population groups. This represents an opportunity for service development.

Sexual health

Commissioners will implement changes to the Sexual Health Tariffs, aid integration of services and increasing the contraceptive provision locally. Other service developments include;

- Provide contraceptive information and contraceptive sessions for women within 6 weeks of delivery.
- Increase LARC provision by 10% on 2010/11 base. (This will be at the agree tariff rate.)
- Point of care testing for HIV and with partners.
- Outreach/4YP service to attend all Haringey sixth forms to provide sex education, advice and screening.
- Service notice on the Chlamydia Screening programme for 2011/12.
- Deliver a comprehensive free condom distribution previously provided by BEH Mental Health Trust.

Improving Access to Psychological Therapy Services (IAPT)

There will be further revisions to the eligibility criteria for IAPT services introduced in 2010/11. IAPT services will only be offered to patients who present with diagnosable depression or anxiety disorders, those with lower depression and anxiety scores will be signposted to Haringey MIND and the Halliwick Centre.

Cost efficiencies

Commissioners are also seeking to agree an ICO 2011/12 SLA that reflects cost efficiencies including a substantial reduction in management costs.

The overall implications of these changes are being worked through but there is an estimated loss of income for 2011-12 of £0.9m in the best case scenario and £3.1m in the worst case scenario. See section 2.8.1.

3.10.3 NHS Islington commissioning intentions

Islington commissioning intentions signal a number of changes that need to be made for the 2011-12 contracting round including efficiency gains resulting from the ICO merger, raising eligibility or thresholds for access for some services and estates utlisation savings.

Within Adult's Services, the following savings and changes are outlined:

- Continuation of the 2010-11 efficiency saving of £600k;
- Management and support services (including corporate & shared services) efficiencies resulting from the ICO merger - £251k;

- Raising of eligibility or thresholds for access and service efficiency savings - £520k;
- Estates space utilisation audit and resulting savings - £322k;
- Recommissioning of sector pathways on diabetes, COPD, Heart Failure and Gynaecology;
- Review of IPCS (Islington Primary Care Service) and integration within the ISIS Consortium community drug service, realizing savings of £12k;
- Identify savings from PCADS (Primary Care Alcohol & Drugs Service) - £22k;
- Review and re-commission parts of the dental pathway, with a view to introducing alternative models of care to reduce dental referrals to secondary care - £150k;
- Development of an APMS contract for the Hanley Road GP Practice;
- Introduction of a Virtual Ward, requiring some of the current community matrons, specialist nurses and district nurses to be redeployed to a seven day week virtual ward service;
- Introduction of an Early Intervention Service at the Whittington Hospital which may require some Community Matron input and support from the Rapid Response Team alongside an interface with the Virtual Ward.
- Delivery of efficiencies of £150k from the provision of Continuing Health Care services to Frail Older People and Young People with Disabilities, a commissioner held budget.

Within Children's Services, the following savings have been detailed:

- Management restructuring and administrative savings - £148k;
- Community Paediatrics, savings of £60k from the team taking direct responsibility for the provision of training under the Healthy Child Programme;
- Speech and Language Therapy, savings of £78k resulting from a change in the service model following a service review;
- Child and Adolescent Mental Health, savings of £204k resulting from a change in the service model following a service review, (excluding the Adolescent Outreach service);
- School Health/Universal services, savings of £295k resulting from a change in the service model following a service review;
- Specialist Children's Services (CDT), savings of £131k.

3.10.4 Longer term contestability of services

National and local policy dictates that there will be an increasing plurality of providers resulting from the any willing provider (AWP) model, niche providers entering more lucrative high cost markets such as home care model and increased competition resulting from commissioners wishing to see a mixed model of provision from NHS, voluntary sector and independent sector providers. Similarly, we can expect to see further competition for some services from GP practices as they start to work collectively to form new provider organisations.

Depending upon the commissioning and procurement resources available to PCTs and the emerging GP consortia, community providers could typically expect to see three to four services being reviewed or market tested each year if the current level of tendering continues. Over a five year period this would translate into an estimated 50-70% of all services undergoing some form of review from a simple revision of the service specification to a full tender process. Services which

are easily defined, with clear measurable outcomes may be more attractive for commissioners to market test, however more complex services integrated with local authorities may be also in the frame as these may present higher perceived savings.

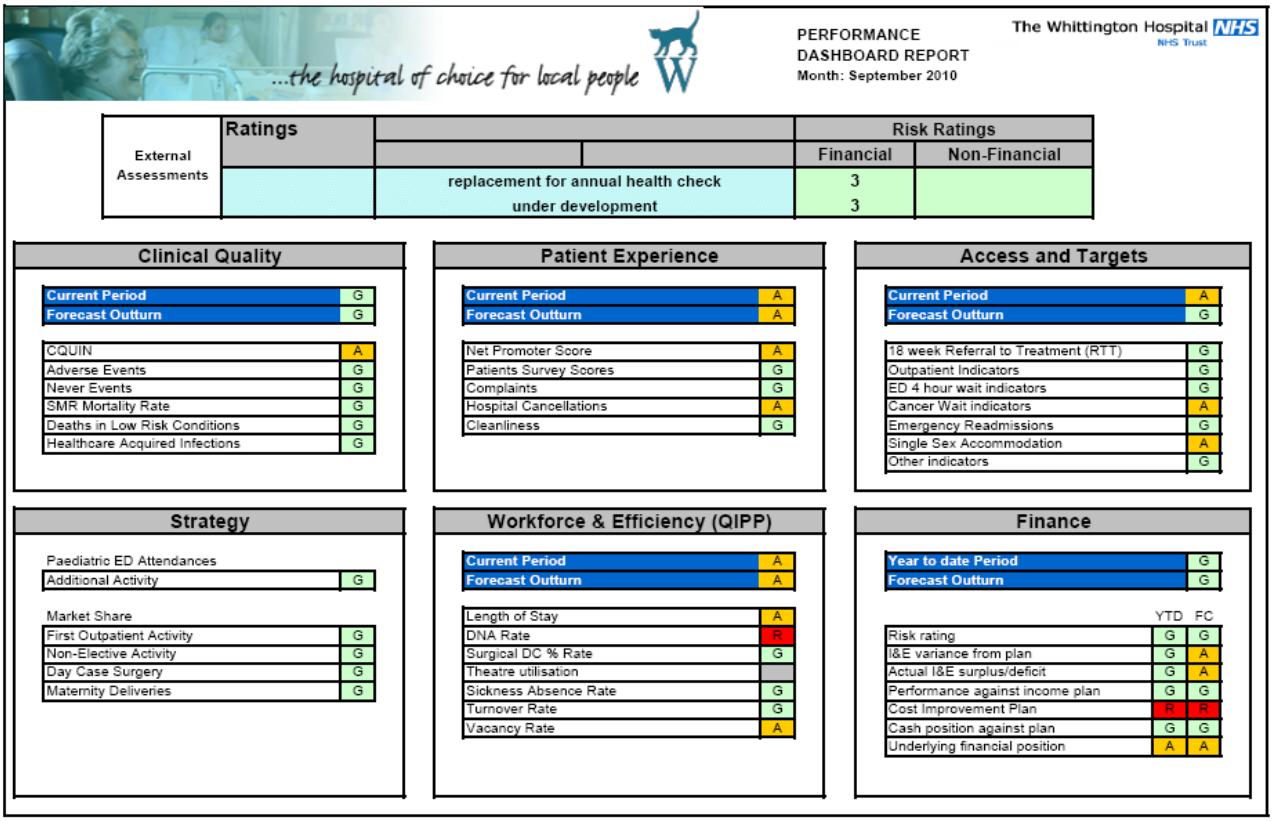
The ICO will work to reduce the risk of competition through collaboration and partnership with other providers. The Alliance has a history of working with local providers to allow a partnership to deliver the full care pathway, thus reducing fragmentation of services, financial inefficiencies and lack of continuity for the patient. Partnerships allow a sharing of expertise or skills in a clinical area or access to a new client group or geographical market. Examples of this include the substance misuse service where Islington Community Services works alongside two third sector organisations – Cranstoun and CRI who have skills in counseling and outreach working. Other examples include prison health where Islington Community Services are the lead provider and contract with CIFT and BEHMHT who provide substance misuse and mental health services. The ICO would wish to continue existing partnerships and seek new partnerships particularly with primary care providers to further integrate care pathways

3.11 PERFORMANCE OF THE WHITTINGTON

The performance of the Whittington Trust is monitored at Trust Board level through the use of a dashboard report covering six core areas of performance:

- Clinical quality
- Patient Experience
- Access and Targets
- Strategy
- Workforce and Efficiency/QIPP
- Finance.

Where no national targets exist, the Trust has established internal targets with the aim of improving performance towards the top decile. The figure below shows the high level dashboard with a summary RAG rating for each key performance indicator.



The performance to September 2010 is shown in the following selections.

3.11.1 Clinical Quality

Clinical Quality — **September 2010**

Overall Mortality Rate

note: refresh of Dr Fosters available for July 2010. Trust data refreshed to September 2010

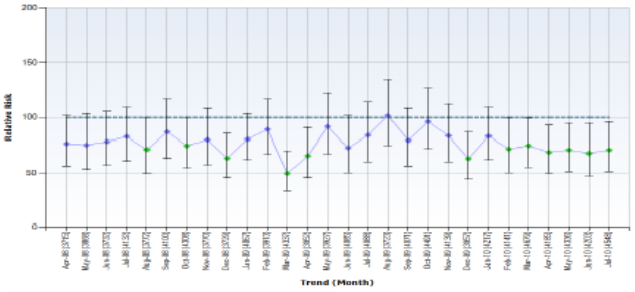
Benchmark (Dr Fosters Intelligence/NHS Choices. Stardardised Mortality Rate, England)

Standardised on total England data = 100, Aug 2009 - Jul 2010)

Trust	RR	Trust	RR
Royal Free Hampstead	69	Ealing	88
University College London	70	Guy's and St Thomas'	89
Imperial College Healthcare	72	Hillingdon	90
Whittington	77	West Middlesex	90
St George's Healthcare	80	King's College	90
Barnet and Chase Farm	81	Whipps Cross	96
Newham	81	North Middlesex	97
Epsom and St Heliers	82	Lewisham	98
Barts and the London	85	South London Healthcare	99
North West Londons	86	Homerton	102
Kingston	86	Mayday Healthcare	106
Chelsea and Westminster	86	Barking, Havering and Redbridge	109

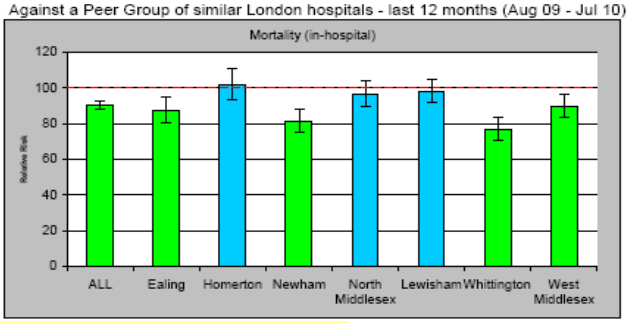
Target to be less than 100

Mortality Rates over time



target: to be Blue/Green rated

Against a Peer Group of similar London hospitals - last 12 months (Aug 09 - Jul 10)



target: to be Blue/Green rated

source: Dr Foster

Deaths in low risk conditions

The contruction of this indicator is still under discussion between Dr Foster and the Care Quality Commission

The current Dr Foster patient safety indicator is shown below

In the 12 months to	Volume of cases	rate per 1000 admissions	National rate per 1000 admissions
Apr-10	8	0.37	0.98
May-10	6	0.27	0.98
Jun-10	Not available		
Jul-10	5	0.23	0.84

Notes

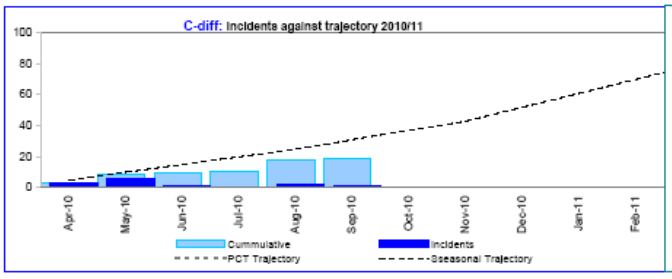
1. Calculated on a rolling 12 months basis (2 months in arrears)
2. All cases are investigated by a senior clinician
3. Trend data not currently available

Clinical Quality — **September 2010**

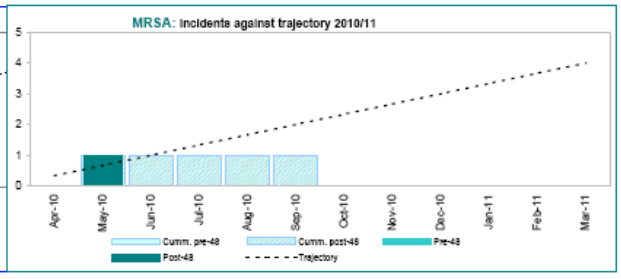
Healthcare Acquired Infections

Contains September data on a month to date basis

Clostridium difficile

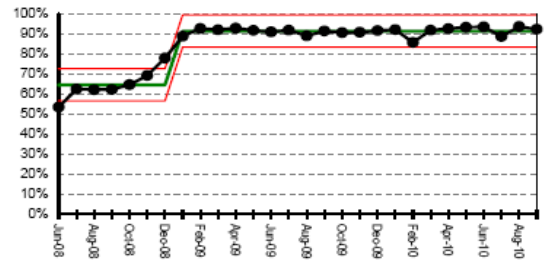


MRSA

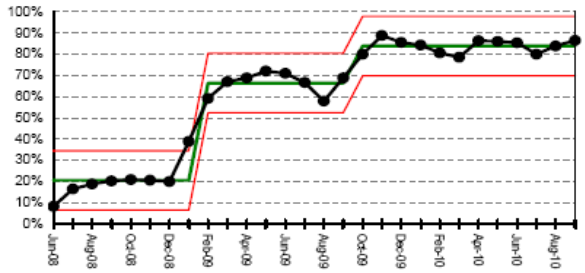


MRSA Screening compliance

Emergency Patients



Elective Patients



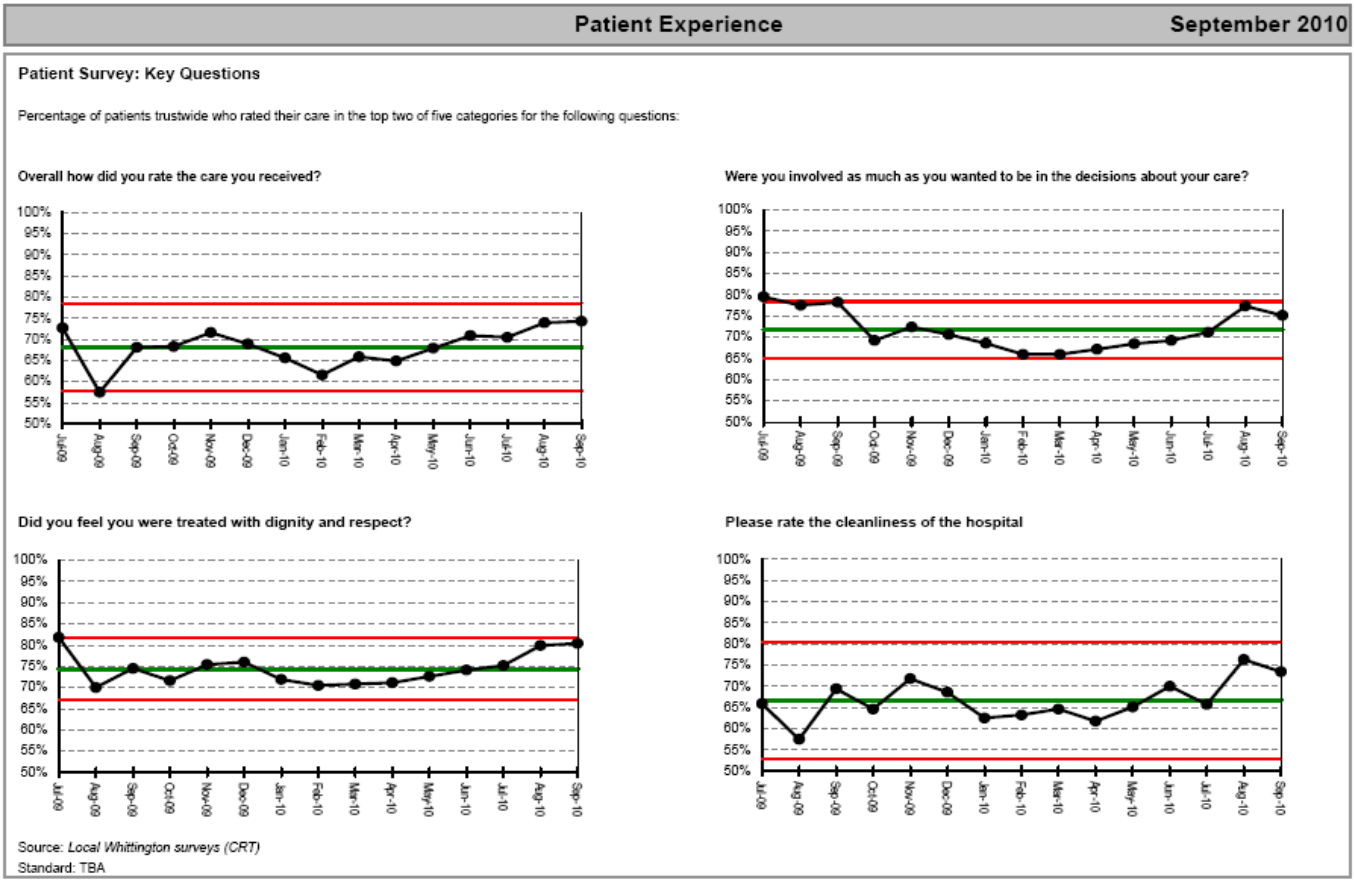
Clinical Quality Performance at September 2010 was good. The Trust continues to maintain its fourth place ranking in London for standardised mortality rates, and is performing well against targets for healthcare acquired infections. A number of CQUIN schemes are still in development with some performance measured at Q4 only. At this stage, a prudent approach has been taken when assessing year – end delivery. Resulting in an amber rating.

3.11.2 Patient Experience

The patient experience dashboard reflects information collected from a number of sources measuring patient experience at the Whittington.

The Trust has opted to measure its performance using an approach well recognised in consumer focussed industries – the Net Promoter Score – which measures a percentage of patients who would positively recommend the Trust to family and friends. This is a challenging measure and the trust is seeking to improve performance in all areas – the most challenging being outpatients and the emergency department.

Patient survey responses for four key questions showed satisfaction levels of over 75%.



3.11.3 Access and Targets

The Trust continues to be challenged in achieving two-week wait targets on a monthly basis. A number of measures are being undertaken which include:

- Reviewing and refining booking and escalation processes
- Extending day of the week capacity

- Liaising with GPs re patient communication.

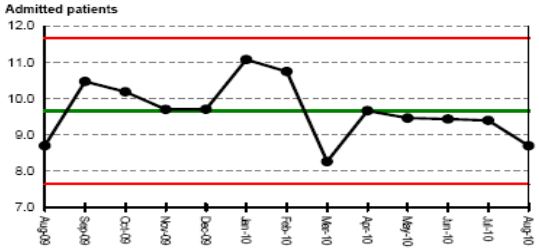
Single sex breaches have occurred on three occasions since April 201. On each occasion, the period of mixing was short but considered necessary to ensure patient comfort and safety at the point the decision was made.

Access and Targets — **September 2010**

18 weeks Referral to Treatment (RTT) indicators — 18 weeks data to August

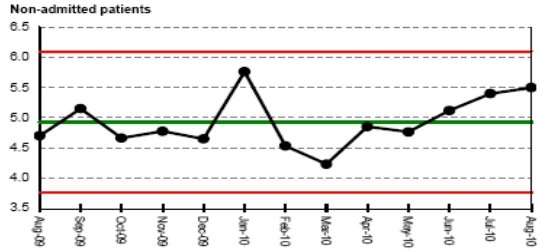
Median Wait for treatment (weeks)

Admitted patients



Standard: TBA
Source: *Monthly 18 week report*

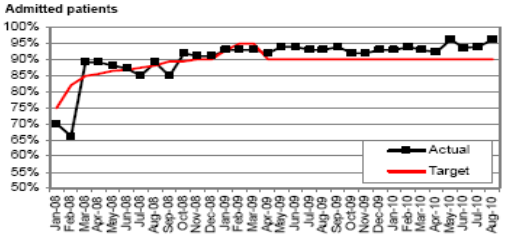
Non-admitted patients



Standard: TBA

Patients treated within 18 weeks (%)

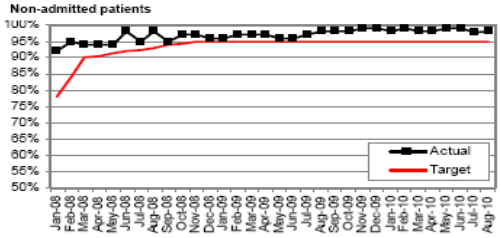
Admitted patients



Standard: 90%

Source: *Monthly 18 week report*

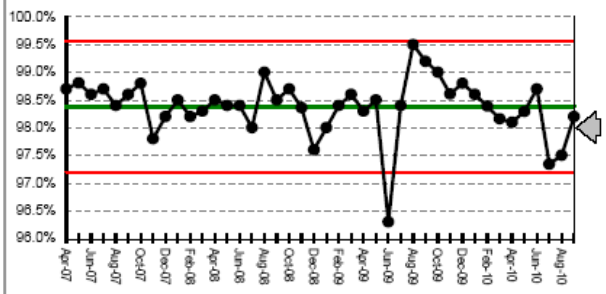
Non-admitted patients



Standard: 95%

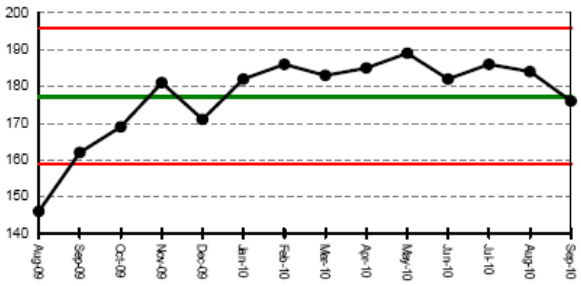
ED waits indicators

Percentage of attenders treated within 4 hours



Source: *EDIS data*
Standard: 98% of ED attenders to be discharged within 4 hours

Median wait (minutes)



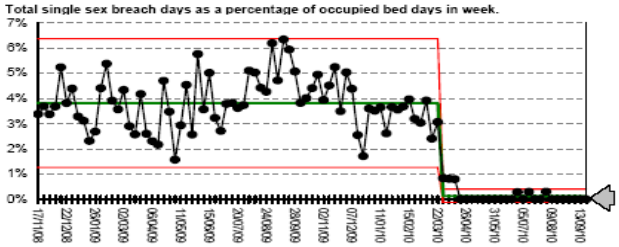
Source: *EDIS data*
Standard: TBA

Access and Targets — September 2010

Admitted Patient indicators

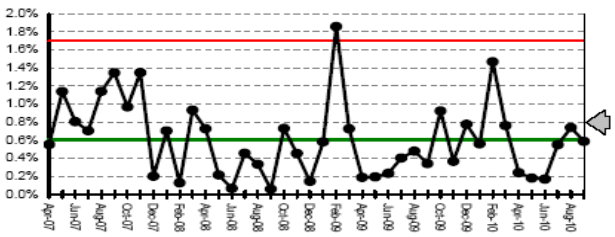
Single sex accommodation

Total single sex breach days as a percentage of occupied bed days in week.



Source: *Daily monitoring by bed managers*
Standard: Zero breaches in patient areas other than critical care and ED

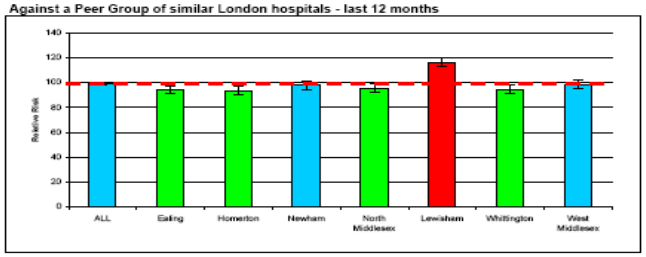
Cancelled Operations for non-clinical reasons



Source: *PAS data*
Standard: <0.8% of operations cancelled for non-clinical reasons (National tolerance)

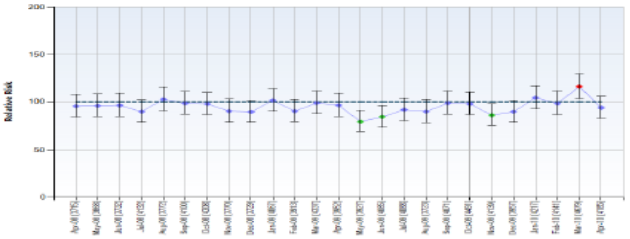
Readmissions within 28 days (relative risk)

Against a Peer Group of similar London hospitals - last 12 months



Source: Dr Fosters - three month lag in data
Standard: to be Blue/Green rated

Benchmark - trend over time (standardised against national data)



Source: Dr Foster Intelligence. Relative Risk = index. Benchmark Year=2007/08
Standard: to be Blue/Green rated

Access and Targets — September 2010

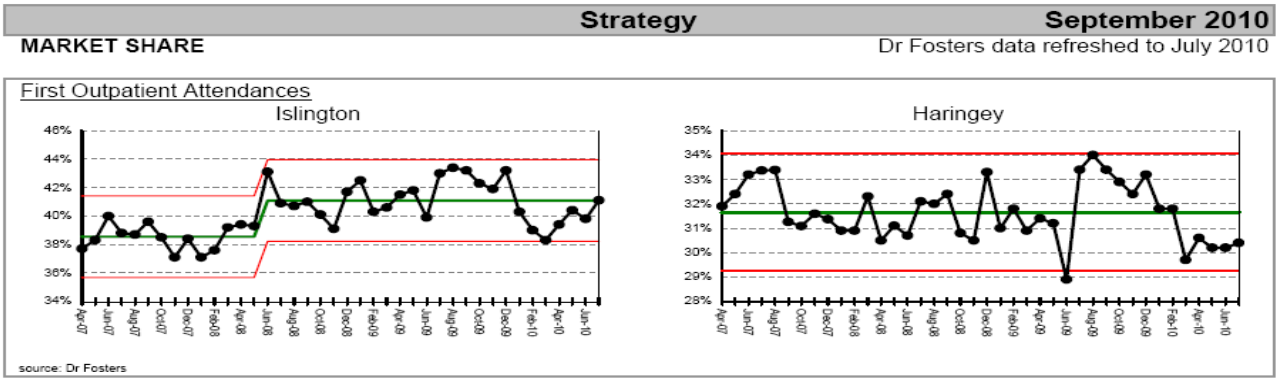
Other Key Targets

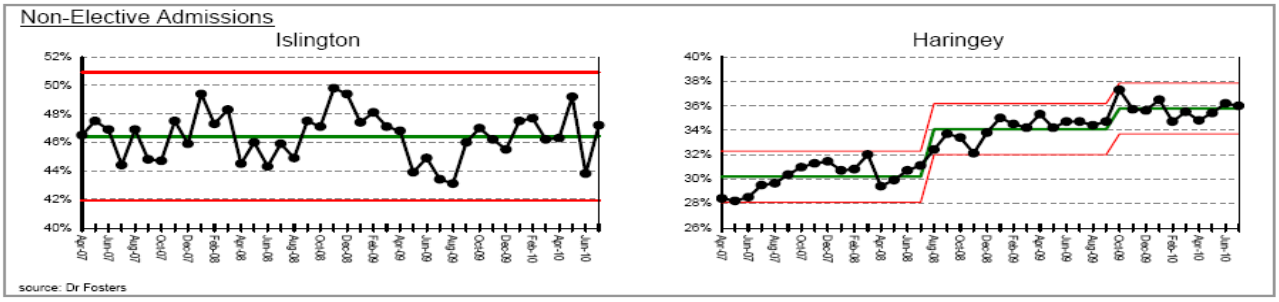
Data is to September 2010 unless otherwise noted

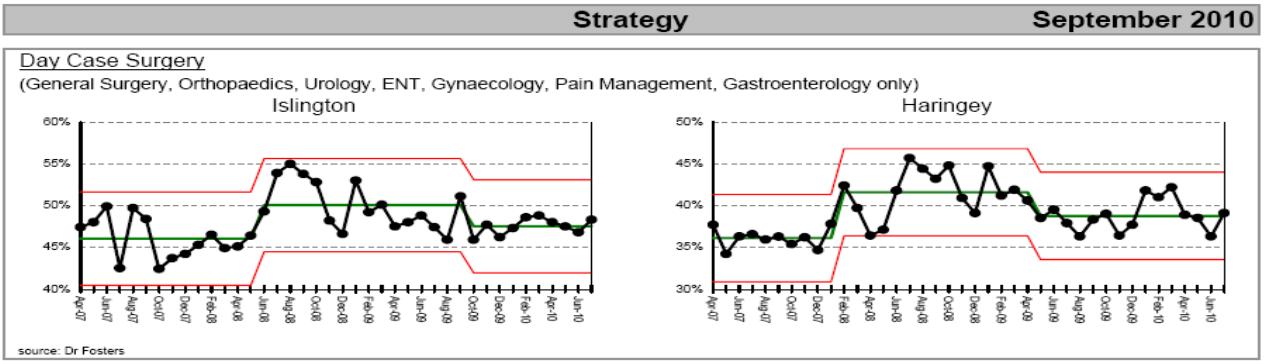
	Criteria	Standard	Month	YTD	Forecast	
Reducing Mortality from Cancer	**% within**		(Aug Data)	(Apr-Aug)		Data source: *CWT dataset*
Wait from urg GP referral until seen	14 days	93%	93.4%	92.5%		
Wait from symptomatic breast referral until seen	14 days	93%	93.8%	92.0%		
Wait from Decision to Treat until 1st Treatment	31 days	96%	100%	100%		
Wait from Decision to treat until 2nd Treatment	31 days	96%	100%	100%		
Wait from GP Urgent Referral until Treatment	62 days	85%	76.2%	85%		
Wait from Consultant upgrade until Treatment	62 days	TBC	85.7%	90%		
Wait from Screening Referral until Treatment	62 days	90%	100%	100%		
Patient right of redress following cancelled operations						Data source: *PAS data*
% operations cancelled for non-clinical reasons	Elective	<0.8%	0.57%	0.41%		
% offers of new binding date within 28 days	Elective	95%	100%	100%		
Delayed transfers of care						Data source: *DTOCs database*
Number of delayed bed-days			97	668	1,316	
% delayed patients as a % of all patients		<=3.5%	1.2%	1.3%		
Reducing Mortality from Heart Disease	**% within**					Data source: *PAS data*
Wait from GP Referral until Seen in RACP Clinic	14 days	>98%	100%	100%		
Emergency bed-days						Data source: *PAS data*
Number of emergency bed-days		7500/m	6,789	46,028		
% Change from last year			11%	9%		
Maternity indicators						Data Source: TBC
Maternity bookings within 12 weeks 6 days	TBA	90%				Data definition TBA
1:1 midwifery care in established labour (bi-monthly)	TBA					Data definition TBA
Reducing inequalities in Infant Mortality						Data source: *PAS/Badger data*
Smoking in pregnancy at time of delivery	% deliveries	<17%	8%	9%		
Rate of Breastfeeding at birth	% deliveries	78%	89%	90%		
Diagnostic waits	**% within**		(Aug Data)	Apr-Aug		Data source: *DM01 Central Return*
Patients waiting from referral until seen	6 weeks		99.7%	99.8%		
NHS number completeness				Apr-Jul		Data source: *SUS (IC Data Quality dashboard)*
% Admissions with valid NHS number		98.1%		93.8%		Standard: National average
% Outpatient Attendances with valid NHS number		98.4%		96.0%		Standard: National average
HRG ungrouped activity				Apr-Jul		Data source: *SUS (IC Data Quality dashboard)*
% ED Attendances without HRG code		100%		99.9%		
% Inpatient Discharges without HRG code		100%		99.9%		
LAS Ambulance - A&E handover						Data source: *LAS monthly report*
% ambulance arrivals handed over within 15 mins	TBA	TBA				Data definition TBA

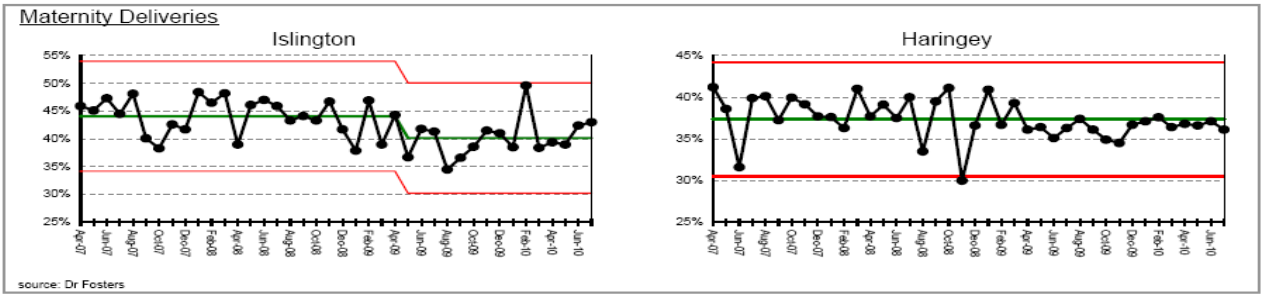
3.11.4 Strategy

The Trust reviews its market share performance each month. Significant growth has been experienced in non elective activity for Haringey PCT. All other activity remains stable.





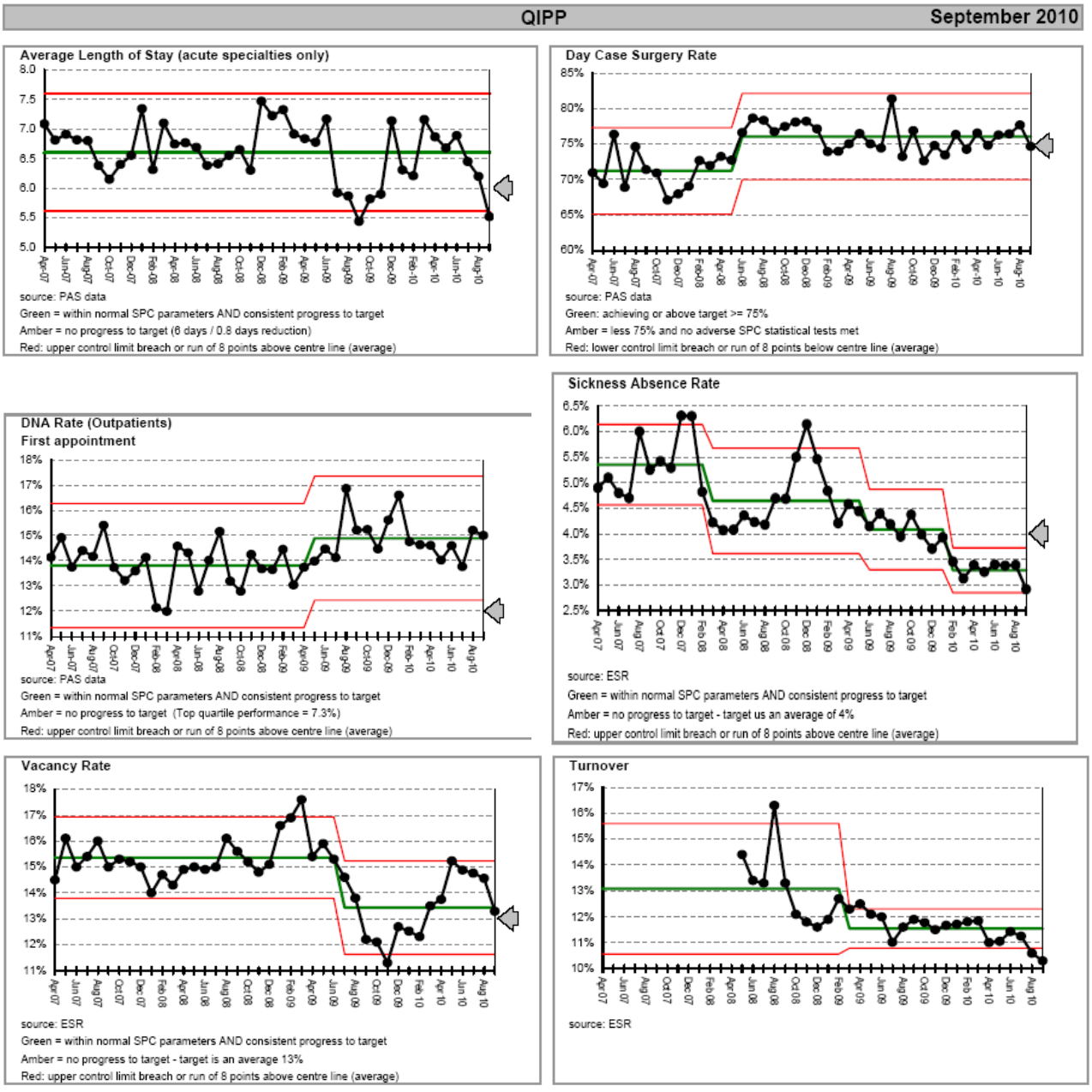




3.11.5 Workforce and Efficiency/QIPP

The Trust has set itself a challenging improvement target for reducing outpatient DNAs. This requires consultant review of all DNAs and discharge back to GP after one DNA unless cancer rules are applied or the Consultant overrules for clinical reasons. A prudent amber rating has been

given to both length of stay and vacancy levels, both of which have demonstrated improvement in recent months. Sickness absence and vacancy rates are proactively managed at the Whittington and considerable success has been seen with below national average sickness rates and below London average turnover staff rates.



3.11.6 Finance

Finance

Year to date Period	G
Forecast Outturn	G

	YTD	FC
Risk rating	G	G
I&E variance from plan	G	A
Actual I&E surplus/deficit	G	A
Performance against income plan	G	G
Cost Improvement Plan	R	R
Cash position against plan	G	G
Underlying financial position	A	A

The Whittington is working towards a financial risk rating of four in line with its requirement to achieve FT status. This translates to it requiring a 1% surplus each financial year. The Whittington is currently reporting a surplus of £0.9m as at the end of September, against a target deficit of £0.2m. Income over-performance is reducing and the target for the year is to break even and this remains the forecast at this stage. In light of the financial position of commissioners within NCL, Acute trusts have been approached for financial assistance and fulfilling its commitment to ensuring the stability of the local health economy's financial viability, a substantial non-recurrent sum has been pledged by the Whittington. This value has been allowed for in forecasting a break even position for 2010/11.

The amber values above were prior to the Whittington's contribution to support NCL sector being agreed. This will be favourably reviewed in subsequent months, following clarification of the likely income levels for the year. The CIP as at month 6 was achieving 88% of the original target of £12.5m (annual value).

The Whittington has achieved its financial targets for the last six years and has been evaluated as "excellent" in the auditors' local evaluation (ALE).

3.12 PERFORMANCE OF THE ALLIANCE

The performance of the Haringey and Islington Community Services Alliance is monitored through the Alliance's Joint Provider Board, Alliance Management Team (AMT) and three directorate management team meetings – Haringey Adults, Islington Adults and Islington Children's Services.

The Joint Provider Board receives a scorecard covering six core areas of performance;

- Access and targets
- Workforce and productivity
- Patient experience
- Finance
- Clinical quality
- Strategic objectives

The following sections describe the Alliance's performance over the first two quarters of 2010-11.

3.12.1 Access and national targets

The key national targets that apply to community services are outlined below with performance data to September 2010.

Access and Targets to September 2010

Access & Targets	Haringey		Islington	
18 week consultant led non-admitted	G (99.89%)	=	G (98.06%)	=
18 week AHP	G (98%)	↓	G (100%)	=
Ethnicity recording	R (42.20%)	↑	A (80.39%)	↑
Ethnicity recording (sexual health)	G (97.94%)	↓	na	
GUM Appointments within 48 Hours	G (100%)	=	na	
New birth visits	na		R (76.92%)	↑
% patients waiting <6 weeks for a 1st appointment	A (62%)	↓	G (70.90%)	↓
Breast Feeding Prevalence	na		A (74%)	↑
Breast Feeding Coverage	na		G (96%)	↑
Childhood Immunisations	na		A	=

Access times – All services are complying with the 18-week AHP and consultant led waiting times. Average waiting times vary by service but are of the order of 1-5 weeks for most services with shorter waits for district nursing and long term condition services. GUM access targets are consistently met in Haringey and good progress is being made with Chlamydia screening at 29.4% of the total target as of (38% through the year).

Ethnicity recording – this measure was traditionally well recorded in Haringey and Islington, however, since the phased introduction of RiO recording performance has slipped as data is extracted from the national spine where recording is generally poor. Services with poor performance have been identified and action plans implemented to improve performance. Currently Haringey and Islington are 42.2% and 80.4% respectively. The NHS London Q1 provider mean average is 71.47% and the upper quartile is 82.55%.

New birth visits within 14 days - For Islington new birth visits are currently red rated, as this is a challenging indicator with a target of 95%. Training has been undertaken with the service to ensure correct data entry. The improvement from the previous quarter's data has continued from 61.32% in Q1 to 76.9% in Q2. Islington performance is line with the London average (Q1) of 74.45%.

Breast feeding at 6-8 weeks – coverage recording for the indicator is very good at 96% but actual prevalence of breast feeding is lower at 74%. Health visitors and the volunteer peer support programme play an important role in achieving this target.

Childhood immunisations - Rates of childhood immunisations across Islington continue to increase and are rated as one of the better performing boroughs across London. However, rates are still below the CQC targets of approximately 90% across all childhood immunisations. A marked increase of immunisations is needed to deliver against the 2010/11 targets. A number of novel approaches have been taken including extraction of GP immunisation data from EMIS clinical systems reconciliation against the community RiO ICT system; working with the lead from the Heart of Birmingham to implement a failsafe system that will pick up the defaulters and operating out of hours clinics to improve access.

Performance against key targets in Haringey has been very strong, with IAPT services continuing to achieve excellent outcomes, GUM 48 hour access remaining at 100% and Chlamydia screening at 29.4% of the total target as of 18th August (38% through the year).

3.12.2 Workforce and productivity

Both Haringey and Islington Community Services received a very favourable annual national staff survey report in 2009. In addition, Islington PCT achieved the top PCT award in the HSJ/Nursing Times Top 100 award in 2008 and came 29th in all employers in 2009. The following workforce indicators below are monitored routinely.

Workforce and productivity targets July 2010

Workforce & Productivity	Haringey		Islington	
Vacancies	G (5.38%)	↓	G (10.61%)	↑
Turnover	G (3.66%)	↑	G (3.98%)	↑
Sickness	A (3.97%)	↑	G (2.48%)	↑
Appraisals	R (62.55%)	↑	R (60.4%)	↑
Stability	G (97.34%)	↑	A (81.20%)	↓
Mandatory training	R (48.56%)	↑	R (41.01%)	↑
% Patient facing time	tbc		tbc	
Unused appointments (DNAs/UTAs)	G (9.00%)	↑	G (9.78%)	↓

Vacancies- both boroughs have vacancy rates on the low side of the London community provider average of 12.7% for Q1. Rates have been around 7-10% for Islington and 5-7% for Haringey since Q1 2009

Turnover – is low in both organisations around 0.8% for this quarter.

Sickness – levels of sickness are lower in Islington than in Haringey, though the latter is in line with the London community provide average of 4.3% for Q1 2010.

Annual appraisal - appraisals are red rated for both boroughs currently but are on track to achieve 95% by November 2010. The NHS London Qtr1 provider mean average is 65.23%. The Alliance

introduced a new appraisal process earlier this year to improve monitoring and compliance with mandatory training but there appears to be some under-reporting.

Stability - Islington, which is red for stability, exit interviews are in place to monitor the reasons for leaving and the retention issues. Haringey and Islington are 97% and 81% respectively and the NHS London Qtr1 Lower quartile is 84%. Islington does however score highly in most areas of the annual staff survey.

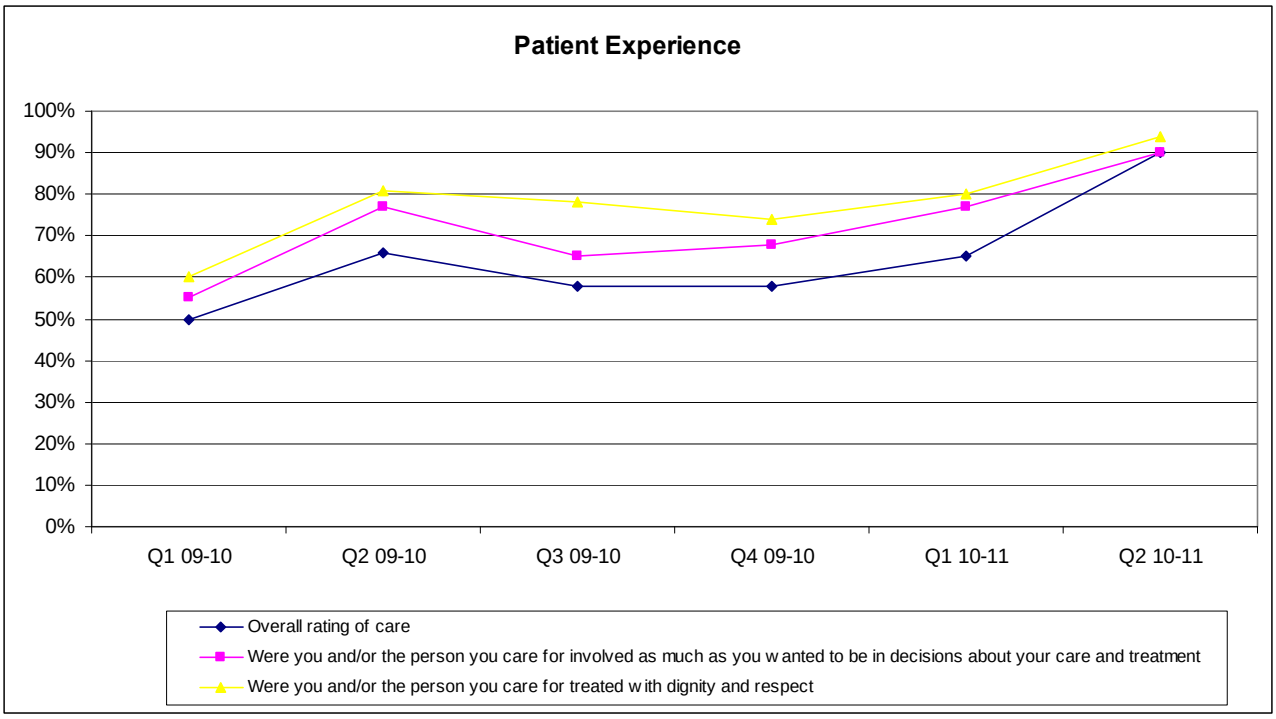
Mandatory training - Haringey and Islington are at 48.6% and 41% respectively and the NHS London Q1 Lower quartile is 60.96%. In order to reach compliance by the end of the year, both providers have introducing Mandatory Training Days to ensure staff take out a minimal amount of time in order to cover the maximum amount of mandatory subjects. The aim is for both to hit an 85% rating by December 2010.

Unused Appointments - are green for Islington, 9.8%, and amber for Haringey 9.0%. The NHS London Qtr 1 provider mean average is 7.76%. For Islington there is more accurate recording of data due to the move to RiO. Work is ongoing to reduce the level of DNAs including mobile phone texting patients to remind them of their appointment.

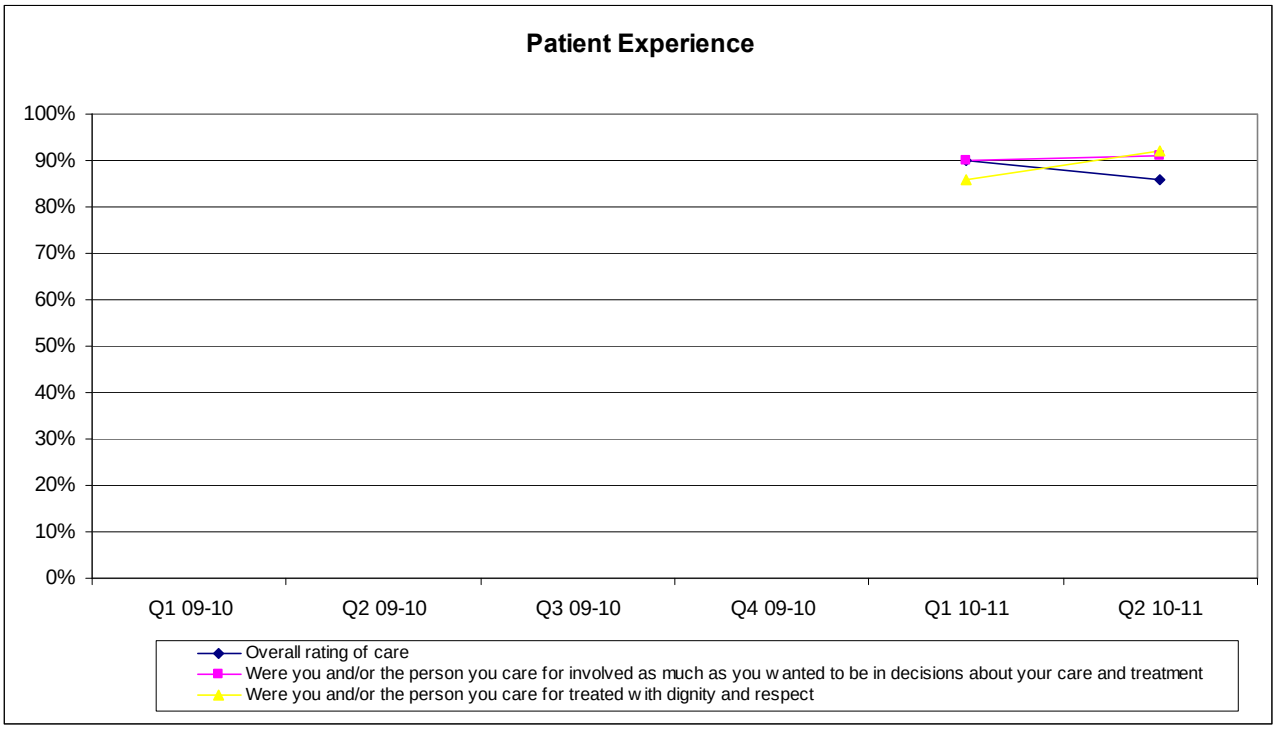
3.12.3 Patient experience

In Islington, Patient experience surveys are collected in real time using kiosks in health centres, web-based (Survey Monkey) and paper forms since early 2009. Results are reported to the on-line Radar reporting tool the following day. In Haringey, reporting using kiosks started in Q1 2010. Performance is shown below for the three key survey questions, and shows current satisfaction scores of around 90-94% for Islington and 86-92% for Haringey.

Patient experience scores Islington Sept 2010



Patient experience scores Haringey Sept 2010



3.12.4 Finance

A summary of the financial performance of the two boroughs is shown below. At the end of the first full financial year (2009/10) for Islington and Haringey Provider services, a financial surplus was achieved by both organisations.

Financial performance April 2009 – March 2010

Finance	Haringey		Islington	
2009/10 Operating (Surplus)/Deficit	G (496)	=	G (1,539)	=
2009/10 Income	G (35,530)	=	G (61,232)	=
Cashflow / Current Ratio	G (1.12)	↓	G (1.05)	↑
Better Payment Practice Code Value %	G (98.46%)	↓	G (95.4%)	↑
Better Payment Practice Code Volume %	G (97.4%)	↑	A (93.2%)	↑
Risk rating	G (3)	=	G (3)	=

The combined surplus for Haringey and Islington Provider Services is £2,035k at 2009/10 year end, which was in line with the control totals agreed with host commissioners and the forecast given to NHS London through the monthly APO monitoring process. This is a surplus of 2.1% against an overall budget of £96,762k.

Financial performance September 2010

Finance	Haringey		Islington	
Forecast Operating (Surplus)/Deficit	G (977)	=	G (2,200)	=
Year to date Forecast Income	G (36,635)	=	G (59,418)	=
Cashflow forecast / Current Ratio	G (1.02)	↓	G (1.14)	↑
Better Payment Practice Code Value %	G (96.57%)	↓	A (74.16%)	↑
Better Payment Practice Code Volume %	A (94.36%)	↑	A (85.89%)	↓
Risk rating	A (2)	=	G (3)	=

Forecast - The forecast figures for Haringey and Islington are based on control totals agreed with host commissioners that were adjusted at the end of the first quarter. The initial control total agreed with NHS Islington was a £1,600k surplus and this was raised to £2,200k surplus in line with the adjusted surplus target for NHS Islington. The process within Haringey has been ongoing throughout the second quarter of 2010/11 and at the end of October 2010 the target surplus is £977k.

Haringey in addition to all the savings previously mentioned needs to identify measures that will reduce the effect of £400k expenditure related to 2009/10. This means that the real surplus achieved by Haringey in 2010/11 will be £1,377k

Income 2010/11 - The forecast for the total Provider income for 2010-11 is £96m. Of this, £40.8m comes from Block Contracts with NHS Islington (with an additional £1.7m non Block Contract income) and £23m comes from NHS Haringey Block Contract plus £1.8 million through an activity based Sexual Health Contract.

Cash Flow - Haringey & Islington - Haringey and Islington Provider Services both have to manage cash flow so that all Creditors including payroll can be paid on a timely basis. In order to achieve this all Debtors need to be raised promptly with the full backing of signed SLAs. Cash management has been achieved ever since the separation of bank accounts from the host PCTs in April 2009. It is imperative that procedures are rigidly adhered to continue the excellent performance on cash management.

PSPP - Haringey & Islington - The Public Sector Payments Policy for Provider Services is shown on the Performance Indicators report. The target set by the Department of Health is that 95% of all invoices are paid within 30 days of receipt. This target has been nearly met by Haringey but Islington has fallen below this target. This indicator is based on the full financial year and although Islington are now achieving all targets, the cumulative figure is still below the Department of Health guidelines. Islington has corrected the procedural fault that caused the original problem at the beginning of the 2010/11 financial year.

Capital - Islington Provider Services has no capital allocation in 2010/11 and the allocation for Haringey has been used to fund the continuation of Capital projects agreed in 2009/10.

Additional Finance Risks – There are two other common financial risks for 2010/11 for Haringey and Islington not included above, these are:

The ability of the Alliance to complete Programme Budget work that will be necessary for the integration with the Whittington Hospital within current budget as there has been no further support funding identified.

Within both PCTs there are a number of ongoing Estates issues. Estates budget and ownership of Capital fall within the Commissioning side of each PCT, equating to a value of £3.1m in Islington and £2.6m in Haringey for community services.

3.12.5 Clinical quality

The Alliance quality improvement agenda is delivered through a Quality Improvement Work Plan covering the three domains of safety, quality and patient experience. The work plan is monitored through the Alliance Quality and Workforce Committee and the Joint Clinical Governance Committee. The Joint Provider Board scorecard has a number of emerging indicators for clinical quality.

Outcome measures – services are starting to collect two outcome measures per service; these will be clinical or patient reported outcomes or where this is not possible process of care outcomes. Further progress will be made over the coming months with most services expected to record and achieve outcomes by Q3 2010.

Incidents – see 3.12.7 below

Appointment outcomes recorded - the outcome of an appointment needs to be recorded in RiO describing whether the patient attended and was discharged, attended and follow up booked, or DNA'd.

CQUIN attainment – The CQUIN targets for the 2010-11 contract are different in Haringey and Islington and cover a variety of markers.

Islington markers:

- Patient experience – all services to achieve an 80% composite satisfaction score
- Reducing emergency admissions for patients long term conditions teams
- Attainment of the *You're Welcome* accreditation for improved access for young people or progress towards meeting the *You're Welcome* criteria for Children's services.
- Improving access for clients with learning disabilities through better identification on clinical systems and

Haringey markers:

- Audit of patient notes to ensure compliance with various agreed standards
- Delayed transfers of care
- Reduction in readmissions caused by inadequate discharge planning
- To improve patient experience when under the care of the Community Trust resulting in more effective, safe, care and high quality patient experience.
- Personalised Care plans for patients with long term conditions and end of life care
- Decreasing hospital admissions for COPD Service patients
- Measuring the performance of methodologies for nutritional care for patients in community beds

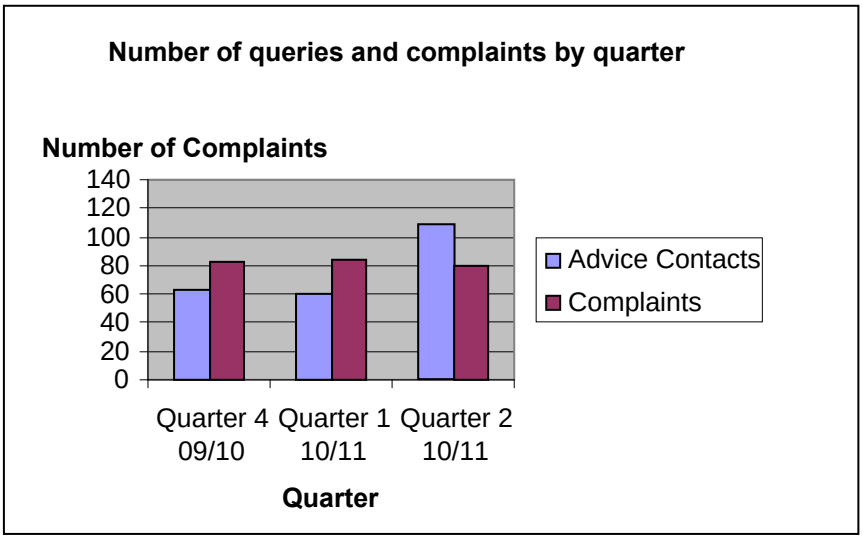
Clinical quality indictors – September 2010

Clinical Quality	Haringey		Islington	
No of services actively collecting outcome measures	currently not available		A(23/26)	=
% of outcome measure targets achieved	currently not available		A (54%)	↑
No of actual incidents recorded as moderate, severe and deaths	12	↓	26	↑
No of incidents with a moderate and higher risk assessment rating	11	=	30	↑
% of outcomes recorded on RiO	R (88%)	↓	G (97.37%)	↓
CQUIN	A	=	A	=

3.12.6 Complaints and PALS advice requests

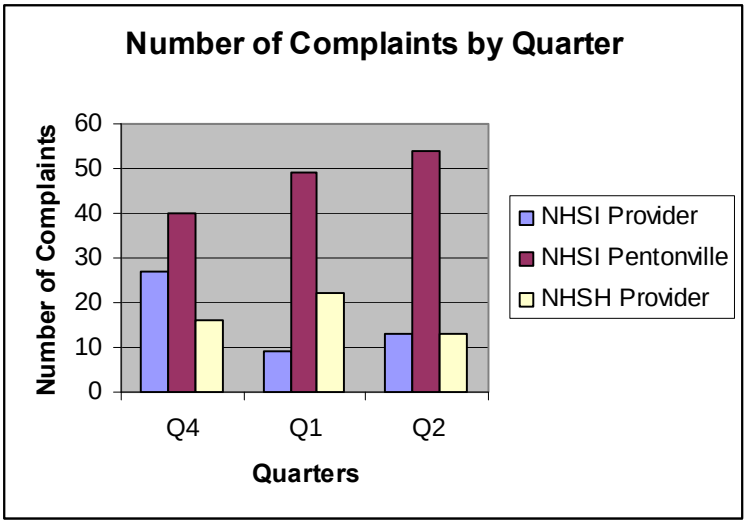
The PALS and complaints team at Islington Community Services provides a service across the Alliance including HMP Pentonville. During quarter 2 2010-11, the Alliance reported a total of 80 provider complaints and 152 advice requests. This compares with the previous quarter (Q1 2010/11) of 84 provider complaints and 60 advice requests and quarter four 2009/10 of 83 complaints and 63 advice requests. Across recent quarters, the numbers of complaints have remained roughly similar, apart from an increase in the number of advice contacts received in the last quarter. This increase maybe attributed to the commencement of patient advice drop-in sessions at HMP Pentonville from September 2010.

Alliance complaints and PALS advice requests over the last 3 quarters



Haringey Community Services complaints represent 16% (13/80) of the total number of complaints and Islington the remaining 84% (67/80). However, of those 67 complaints, the majority 68% (54/80) concern HMP Pentonville, and 16% (13/80) concern other NHS Islington Community Services. There has been an increase in the number of complaints received concerning HMP Pentonville healthcare during this quarter.

Alliance complaints by service area.



Of the 13 complaints received in quarter 2 2010-11 for Islington Community Services (excluding HMP Pentonville), district nursing received four complaints and nine other services received one complaint.

Of the 54 complaints received concerning HMP Pentonville Healthcare, 26 related to NHS Islington (NHSI), 26 concerned Camden and Islington Foundation Trust (CIFT) and 2 concerned Barnet, Enfield and Haringey Mental Health Trust (BEH MHT). The highest number of complaints (20/54) concerned GP services followed by the Substance Misuse service (19/54).

For Haringey Community Services, 13 complaints were received, 3 concerned physiotherapy services. Both Greentrees (Chestnut Ward) and district nursing received two complaints. Other services received only one complaint in this quarter. This differs from the previous quarter in which sexual health received four complaints; district nursing and podiatry received three complaints. Last quarter physiotherapy received only one complaint but Greentrees received the same number of complaints in the previous quarter

Complaints by Risk Rating and Trust

The majority of Islington complaints received a low or very low risk with seven complaints having a moderate risk rating. There were no high risk complaints. Therefore, approximately 10% of complaints had a moderate risk rating with the remaining 90% being low or very low risk. HMP Pentonville complaints showed a slightly lower level of risk to other NHS Islington complaints but this difference was minimal (HMP Pentonville = 9%, NHSI other = 15%). The substance misuse service at HMP Pentonville was the only service with more than one moderate level risk with three moderate risk complaints.

Haringey complaints present a similar picture to Islington where the majority of complaints are low and very low risk. There was one complaint of moderate risk and one of a high risk. This means that moderate and high risk complaints are 15% of the total number of complaints. This is an improvement on the previous quarter where 24% were complaints with a moderate or high risk associated.

Number of Complaints Upheld and Not Upheld

Overall within Islington 31% of complaints were at least partially upheld, including HMP Pentonville. When considered independently 31% of HMP Pentonville complaints were partially upheld which is a marked improvement on the previous quarter when 45% of all complaints were at least partially upheld. Nine complaints remained open. However, some of the Pentonville services continue to show a relatively high number of complaints, which are partially upheld, such as the CIFT substance misuse service (7), CIFT In-Reach Mental Health Service (2), and the Islington GP service (4).

Of Haringey community health complaints, 31% were at least partially upheld with four complaints remaining open. This is an improvement on the previous quarter when 64% of complaints were at least partially upheld and is in line with quarter 4 2009/10 where 31% of complaints were also partially upheld. This is at a similar level to NHS Islington. No service had more than one upheld complaint.

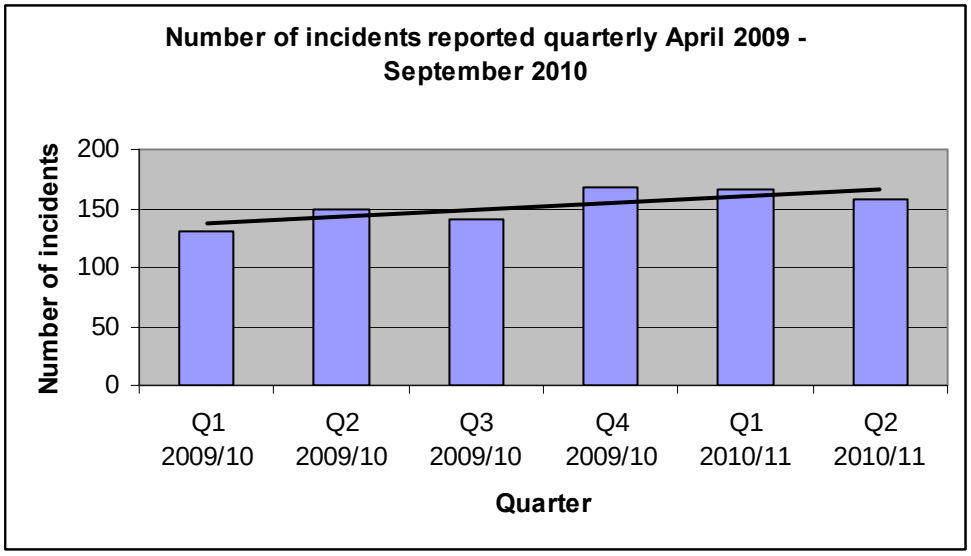
Complaints response times

In quarter 2 all complaints letters were acknowledged within the two day target response time for all Alliance services. Overall 90% of complaints were responded to (or are still open) within target or negotiated response times. In Haringey, only one complaint response was provided outside of the 25 day target response time. In Islington provider services (excluding HMP Pentonville), the target was achieved in all but three cases where the response was only one or two days outside the target response time. All HMP Pentonville responses were within target response times.

3.12.7 Incidents and SUIs

For quarter two Islington reported 158 incidents compared with 166 in the previous quarter. The highest number of incidents were reported by Simmons House (Tier 4 inpatient CAMHS) 31 incidents mainly disruptive and aggressive behaviour; district nursing, 20 incidents mainly medication related; and Pentonville substance misuse, 14 incidents which relate to a range of incidents. The main trends related to disruptive & aggressive behaviour (36); accidents (21); medication (19) and self harm (17).

Incidents reported by Islington Community Services.



The severity of incidents are graded below for quarter 2; seven incidents were reported as severe and another three resulted in death.

No harm	65
Low	61
Moderate	21
Severe	7
Death	4
Total	**158**

4. POST MERGER INTEGRATION PLAN

4.1 THE STRATEGIC RATIONALE FOR THE TRANSACTION

PCTs will be focusing on developing support arrangements for primary care's role in GP Collaborative led commissioning, which will start to undertake commissioning from 2012 and to commission new care pathways. At the same time, there is a huge challenge of how to manage, increasing demands on the healthcare system in an environment of cost restraint and how best to maintain health whilst reducing or at least controlling the demand for expensive acute care.

Health policy is moving strategic development of acute care towards local hospitals delivering low risk high volume services and the shift of more complex care to major acute and specialist hospitals. Less complex care will move from acute provision to local hubs and other community providers.

The strategic challenge to both the Whittington Hospital and Islington and Haringey Provider services is how to create viable services that meet the needs of the local population in an efficient, transparent and co-ordinated way. The proposed merger offers the opportunity to do something different and innovative; to develop a partnership between acute and community services in partnership with primary and social care, with the goal of creating a new integrated organisation with a focus on the local population which will be clinically and financially sustainable and a successful FT.

4.2 STRENGTHS OF EACH ORGANISATION

In particular, the new organisation will take advantage of the identified complimentary strengths of the senior management teams. The strengths from community provider services include:

- Focus on prevention of ill health
- Focus on self management in the community
- Promoting independence
- Risk management
- Autonomous and multi-site working.

The strengths from acute services include:

- Skills and facilities to care for patients who are acutely medically or surgically unwell and/or requiring emergency treatment and intervention.
- Wide portfolio of services, excellent surgery, anaesthetics and ITU

- Excellent and well established links with specialist tertiary services.
- Stable organisation with an established brand
- Reputation for teaching and training.
- Ability to influence general practice and develop relationships between consultants and GPs.
- Information management expertise.
- Management of the estate and space utilisation.
- Business acumen forged by FT imperatives
- A member of UCLP

4.3 AN OVERVIEW OF THE KEY TRANSACTION OBJECTIVES

The overall objective is to create a patient focused organisation, which can provide most community and acute care, in partnership with primary and social care, to its catchment population. The integrated care organisation will offer a range of health benefits to local people including:

4.3.1 Clinically led service with a single governance structure

The new organisation will operate a system of integrated care built on strong clinical leadership combining a primary, secondary, community and social care approach to the management of patients. Creating a single organisation with a single governance structure will ensure the highest standards of safety and quality and enable benefits to be realised more easily and reliably than through collaboration across organisational boundaries.

4.3.2 Excellent Clinical Care

The integrated organisation will offer better clinical care than were provided by separate acute and community services. Vertical integration will provide a framework within which the re-design of pathways on a whole system basis can happen, supporting prevention and enabling people to manage their long term conditions rather than just focusing on its acute management.

4.3.3 Innovation, self-management and care closer to home

The integrated organisation will place a significant emphasis on innovation, an increased emphasis on self-management and care closer to home. Professionals will work innovatively along the whole care pathway improving the quality of care for patients and avoiding unnecessary hospital admissions thereby shifting care closer to home.

4.3.4 Improved Health outcomes

In the medium to longer term, creating an organisation with better models of care integrated with primary and social care that are designed to meet the specific needs of the local population will lead to improved health outcomes.

4.3.5 Value for money.

Integration will create opportunities for economies of scale and deliver financial efficiencies. There will also be scope for using acute and community contracts imaginatively to procure pathways of care and to incentivise keeping patients well.

4.3.6 More opportunities for NHS staff.

Integration offers new and different training and development opportunities and career pathways for healthcare professionals.

4.4 THE KEY PRINCIPALS UNDERPINNING THE APPROACH TO THE TRANSACTION

- The partners in the ICO have worked towards developing a model of delivery that is based on integration, regardless of the technical nature of the transfer transaction.
- Continuity is important. To enable sound governance Community services will join the Whittington initially as a stand alone division to ensure transition. As work is taken forward to integrate clinical pathways there will be a parallel process of reviewing corporate governance structures so that by April 2012 significant changes will have taken place to support a newly created ICO.
- It is recognised that this is not a bilateral process and there are a range of key partners who need to see the benefits of the transaction. We will ensure GPs, local authorities and patient groups understand the principles, rational and implications of what we are doing.

4.5 THE TRANSACTION TIMELINE

The key milestones are as follows:

- Full Business Case to be agreed by the three Trust Boards November 2010.
- Formal consultation with staff due to transfer Dec 2010 to February 2011.
- Submission of business case to NHS London for approval 17 January 2011.
- Community services to formally join the Whittington Hospital on 31st March 2011.

The integration phase will take place during 2011/12, during which the building blocks for the new organisation will be put in place. The transformation phase will start from 2012/13 onwards, when a fully integrated organisation emerges.

4.6 KEY MILESTONES FOR THE INTEGRATION

Milestone	Start	Finish
Agree and sign Heads of Terms	6 Sept 2010	15 Oct 2010
Submission to CCP	18 Oct 2010	18 Oct 2010
Staff TUPE consultation document drafted	20 Oct 2010	20 Nov 2010
Due diligence work, internal and external review	4 Oct 2010	17 Dec 2010
Full Business Case to Haringey, Islington and Whittington Boards for approval	15 Nov 2010	27 Nov 2010
Staff consultation process	1 Dec 2010	28 Feb 2011
NHS London FT early assessment process	1 Dec 2010	28 Feb 2011
Contracts and Transfer Agreement signed	3 Jan 2011	28 Feb 2010
Submission to NHS London for start of review process	17 Jan 2010	
Approval from CCP		31 Jan 2011
Submission to NHS London Capital Management Group	27 Jan 2010	31 Jan 2010
Submission to NHS London Capital Investment Committee	1 Feb 2010	8 Feb 2010
NHS London transaction approval letter received		15 Feb 2010
Staff receive notification of transfer of employment	1 March 2011	31 Marc 2011
Staff transfer to ICO		1 April 2011

4.7 POST MERGER PLANS

4.7.1 Clinical transformation

A large number of services and pathways will be reviewed as part of the clinical transformation programme, some examples of these include:

- Agree priority clinical pathways for transformation e.g. long-term conditions, older people and urgent care.
- Transfer appropriate out patient services from hospital into the community
- Increase pre assessment work into the community
- Transfer some ante-natal services into the community
- Increase phlebotomy provision in the community.
- Increase in reach into the hospital
- Avoid admission and reduce length of stay
- Promote a patient safety first culture
- Promote clinical excellence through audit, research, training and development
- Ensure opportunities are available for acute and community staff to train together.

- Develop and implement models for redeploying staff flexibly across the organisation, supported by appropriate training and development.

4.7.2 Finance and Payroll

- All agreed staff included within the transfer will be added to the Whittington payroll
- Existing Haringey payroll SLA notice given and TUPE applies (this should happen before ICO begins to operate)
- 2011/12 budget for community services added to Whittington ledger
- Current community finance staff will continue to work on closing 2010/11 accounts as well as working on 2011/12 ICO matters
- Accounts payable and receivable activities will be added to the current Whittington service and current Whittington systems will be used
- Payment/receipt of old year invoices will form part of the due diligence process and therefore depend on the extent to which creditors and debtors are transferred to the ICO's budget
- Ensuring that the ICO financial systems, policies and standards are consistent with achieving the financial governance and function requirements of an FT
- Develop further the use of service line reporting across the ICO.

4.7.3 ICT

- Develop a unified IM&T Strategy for the ICO
- Migrate to a single user interface to access electronic patient records
- Rationalise IT systems to improve patient safety and save operational cost
- Standardise IT infrastructure across the ICO to enable fast, secure and resilient communications internally and externally
- Migrate to ICO wide approach to information governance, training, IT security

4.7.4 Estates and Premises Management

- Review hard and soft service levels and implement performance management regime
- Develop integrated system for central returns (i.e. ERIC/PEAT)
- Review space utilisation and occupancy needs – identify and develop opportunities to reduce the occupied estate
- Revise the Estates Strategy
- Review the provision and value for money of procurement services
- Review the provision and value for money of decontamination services
- Review the provision and value of money of the medical physics service
- Review the integration of health & safety governance arrangements

4.7.5 Human Resources

- Review of compliance and vital signs (recruitment, appraisal and mandatory training)
- Align H R departmental processes and standard operating procedures
- Project plan to harmonise policies and HR practice
- Devise consult and implement fit for new organisation purpose and cost effective HR structure
- Development and delivery of integrated people strategy including staff engagement
- Align workforce information reporting for Board and other purposes
- Alignment of payroll and pensions service
- Transfer of ESR systems
- Back office rationalisation plan
- Review of OH service delivery

5. ORGANISATIONAL DEVELOPMENT PLAN

5.1 INTRODUCTION

The integration of health services delivered by the ICO will be critical to its successful provision of services to patients, and thus its success as a foundation trust.

It will implement and achieve change through its:

- Strategy
- Values and culture
- People
- Structure and systems
- Corporate responsibility

Also through engagement of:

- GPs
- Governors
- Patients
- Heads of service, senior clinicians and other managers
- Staff
- Trade union/professional organisations

5.2 STRATEGY AND VISION

The ICO will build a strong vision of its strategic direction to demonstrate how it will deliver better, streamlined care for its patients. The vision is described in section 2 – Case for Change.

It is through the delivery of this strategic vision that The ICO will be able to create an organisation where its users and service deliverers will be committed to its success

5.3 VALUES AND CULTURE

We will need to be able to combine the best aspects of the culture and values of community and acute services, to develop values and culture, which will support the delivery of new ways of delivering care for the benefit of patients. These will provide the bedrock of how the organisation and its people do things and treat people, whether it is service users or other service delivers. Staff will be engaged in developing these values to engendering their commitment to different and better way of doing things.

5.4 PEOPLE

The success of the ICO will be delivered through its people and so the following will be particularly critical:

- Staff appraisal
- Clinical skills
- Education and development of staff
- Leadership skills

The programmes, including leadership development, will be delivered or available for staff within the integrated organisation, thus maximising the use of resources and expertise within Whittington Health. The aim will be for staff to enhance their skills and expertise to enable them to deliver the best care in the most appropriate setting for patients.

The development of the Trust Board will build on its current expertise and through a Board Development Plan over the next 12 months. It is through this programme that the newly formed integrated care organisation will be developed. It will also contribute to developing its fitness to achieve foundation trust status.

5.5 STRUCTURE AND SYSTEMS

The organisation's structure will be critical to facilitating the delivery of better integrated services and the Trust's strategic objectives. It will ensure there is clarity in relation to:

- Decision making
- Accountability
- Clinical governance
- Corporate governance
- Performance management

The organisation will also need to be nimble and quick at decision making and implementation with patient safety at its centre.

The Executive Management Board will comprise the directors of the organisation and will be the key decision-making body, reporting to the Trust Board.

5.6 CORPORATE RESPONSIBILITY

The ICO has an important responsibility to conduct its business in an ethical way taking account of its impact on:

- The health and wellbeing of local people through service provision
- The wealth and wellbeing of staff as the largest employer in the area
- The local economy including local suppliers and businesses
- The environment
- Recognising and celebrating the diversity of the local community and its staff

Whittington Health's corporate social responsibilities will be woven through its day to day operations and governance to ensure that these are met.

5.7 DEVELOPMENT PLAN AND SUCCESS CRITERIA

A detailed plan identifying actions and priorities will be developed to ensure the delivery of an organisational development plan.

Criteria for evaluating the success of the organisational development strategy should be devised and agreed as part of the overall implementation. The criteria could include:

- Achievement of its strategic and operational objectives
- Increased value for money and productivity
- Contribution to addressing health inequalities
- Achievement of performance targets
- Improved patient satisfaction ratings
- Improved staff satisfaction ratings
- Improved relationships with other providers and the local community
- Achieving Foundation Trust status

6. INTEGRATION RISKS

Description	Action/Progress	Data for Resolution	Owner	RAG rating
FBC needs to be completed and approved by NHS London and Trust Boards.	Final draft completed 15/11/10 and agreed by Haringey, Islington and Whittington senior management teams.	31/11/10	IK	A
Obtain approved from CCP	Initial meeting held on 9 September 2010 to clarify information requirements and documents sent 17 September 2010. Fast rack application agreed with CCP.	Maximum 120 working days from submission.	IK	A
Confirm that the transaction contributes effectively to Whittington FT trajectory.	Initial KPMG feedback on FT viability positive. ICO IBP to be drafted post Board meetings.	31/01/11	RL	A
Currently 3 different information systems across the three organisations.	Discussed at Project Team 21st September 2010 and sub group established to look at risks and mitigation.	31/01/11	GW	A
Agree the future direction for the estate currently owned/occupied by PCTs.	Discussed at Project Team 4th November and sub group established to look at the estate issues. Awaiting further DOH guidance post White Paper.	31/01/11	PI	G
Need to ensure full staff engagement and commitment in process and to this new organisation.	HR subgroup established and developing OD strategy. Regular Intranet updates published and meetings held with community and Whittington staff Transformation sub group has met several times to	31/12/10 31/11/10 31/12/10	IF/MB DS MdS/KS	G

	agreed and start work on priority areas.			
Haringey GPs have formally expressed concern about the acute trust hosting community services in particular they have rated the following areas as weak: • Development of care pathways. • Support for local commissioning. • Value for money. • Quality and productivity.	GPs invited to attend the Programme Board. Roadshows underway targeting GPs audience. NHS London funded project to improved GP engagement underway report. Lead a member of Project Board. Business case drafted to address specific concerns.	In place Ongoing Ongoing 31/10/10	IK CEOs JS IK	**G**
In addition, GPs they have expressed concern about provision of services in the east and use of North Middlesex Hospital.	Roadshows and meetings. FBC	Ongoing	CEOs IK	**G**
Section 75 agreements require review	Plan to take paper to Islington Executive February 2011.	28/02/11	IK	**A**
Need to agree name for new organisation	Proposed name agreed by Programme Board, to sign off at Board meetings	31/11/10	CEOs	**G**
Consideration of 3rd party TUPE arrangements.	HR sub group producing final TUPE staff list.	31/11/10	MB/IF	**A**

7. EQUALITY IMPACT ASSESSMENT

Policy or service being assessed: **Integrated Care Organisation Business Case**
Summary of Policy/Service To create a new organisation based on the legal structure of Whittington Hospital NHS Trust encompassing the Provider Alliance for Islington and Haringey.
Date of assessment: 13/10/10

Stage 1

Question	Please tick to indicate	
1. Is this a new or existing policy or service?	**New** √	**Existing**
2. What is the expected outcome of the policy/service? (e.g. aims, objectives and purpose of the policy/service).	A new organisation to offer integrated pathways of care to the residents of Islington and Haringey.	
3. Does the Policy/Service link to others? If **Yes** please state below	**Yes** √	**No**
4. Who is intended to benefit from the Policy /Service and in what way?	Catchment area of the ICO, primarily residents of Islington and Haringey.	
5. How is the Policy/Service to be put into practice? Who is responsible?	The Boards of Whittington Hospital NHS Trust, NHS Islington and NHS Haringey.	
6. How and where is information about this policy/service published (e.g. through groups, forums, committees the Trust's intranet/internet)	Minutes of the Boards held will be accessible via websites and intranet facilities.	
7. What regular consultation is carried out with different communities and groups regarding the Policy/Service (e.g. groups or forums within the Trusts' external groups and communities).	Extensive work has been taken place via the Programme Board comprising of representatives from the sponsoring bodies. A number of work streams have involved staff side representatives and Scrutiny and Overview committees are aware of the process and will be informed officially in November 2010.	
8. Are there any concerns that this Policy/Service provision could have an impact with regard to equality legislation, that has not been addressed as part of the policy, specifically in relation to:	**Yes**	**No**
Age		√
Disability		√
Gender		√
Ethnicity (Race)		√
Sexual orientation		√

Religion/Belief		√	
Dignity and Human Rights		√	
9. If YES to one or more of the above please state evidence.	N/A		
10. Do the difference amount to discrimination	**Yes**	**No**	**N/A** √
11. If YES could it be justifiable e.g. on grounds of promoting equality of opportunity for one group? Indirect discrimination can sometimes be justifiable when it is target at a particular of 'hard to reach group.	**Yes**	**No**	**N/A**
12. If YES please give reasons			
13. From the initial EIA at stage 1, should there be a full Equality impact assessment carried out, ensure you addressed those areas identified in question 8? Please note reasons.	No		
14. Please indicate who will be responsible or leading of the full EIA being conducting, and the expected date of completion (e.g. action plan, indicated end dates for actions).	N/A		

Key Equality Legislation:

Sex Discrimination Act 1975
Equal Pay Act 1970
Equalities Act 2006
Gender Recognition Act 2004
Race Relations Act 1976
Race Relations (Amendment) Act 2000
Disability Discrimination Act 1995 and 2005
Human Rights Act 1998
Mental Capability Act 2005

8. TUPE STAFF CONSULTATION

8.1 TRANSFER OF UNDERTAKINGS REGULATIONS

Staff employed by NHS Haringey and NHS Islington Community Services will transfer, under TUPE Regulations and the Cabinet Office's Statement of Practice "Staff Transfers in the Public Sector" (2000), to The Whittington Hospital NHS Trust on 1 April 2011, with their existing terms and conditions of employment. Existing pension provisions will be unaltered and continuity of NHS employment will be preserved.

However, if, following consultation, an employee formally objects to a transfer s/he will not transfer to The Whittington Hospital NHS Trust. The effect of a formal objection is similar to resignation as there is no entitlement to redundancy or compensation. Employees who formally object will not be employed by either NHS Haringey and NHS Islington Community Services or The Whittington Hospital NHS Trust from the date of the transfer.

8.2 EFFECTS OF THE PROPOSAL - THE IMPACT OF THE PROPOSED CHANGES ON STAFF

NHS Haringey and NHS Islington Community staff from the services which are included in the transfer agreement will transfer in their entirety to the Whittington Hospital NHS Trust. All staff in support functions in NHS Haringey and NHS Islington Primary Care Trusts who spend 50% or more of their time on Community Health Services will transfer under TUPE regulations. As a result, for the purposes of the TUPE consultation process, all affected staff will be identified. Staff wishing to appeal against inclusion in the transfer may do so by stating the grounds of their appeal.

It is not anticipated that there will be any initial change in role and few changes to workplace locations, although this may be affected by any subsequent service reviews. Any such changes will be managed in line with change management policies and best practice.

8.2.1 Staff transferring

A list of all departments that are proposed to transfer to The Whittington Hospital NHS Trust are detailed at sections 2.4.1 and 2.4.2.

8.2.2 Consultation Period and Feedback

It is anticipated that there will be a three months formal consultation period from 1 December 2010 to 28 February 2011. Formal consultation will take place with staff side representatives for staff employed by Community Services functions of NHS Haringey and NHS Islington Primary Care Trusts, as well as The Whittington Hospital.

All staff will have the opportunity to attend consultation meetings to enable them to raise any concerns or provide other input, and there will be a facility for 1:1 meetings if these are specifically requested.

9. ASSURANCES AND TESTS

9.1 DH EIGHT NATIONAL TESTS FOR TRANSFORMING COMMUNITY SERVICES

Eight National Tests for T.C.S

Test		Business Case
1.	Improving outcomes. For patients and enhance patient care.	Section 2.5.1. Case for change and Benefits of integration.
2.	Improving quality. Of service outcome and shift from Acute to out of hospital care.	Section 2.6.
3.	Service Integration. To improve patient care and integrate service. Skills to increase prevention.	Section 4. Organisational Integration.
4.	Stakeholder Engagement Extent of support and ongoing engagement.	Dates times, venues and numbers public, staff and interagency engagement Supporting letters.
5.	Efficiency improvements To deliver efficiency improvements and reductions in costs.	Section 2.7 Financial analysis.
6.	Infrastructure utilisation. To increase utilisation of efficiency. To back office estate and other infrastructure.	Section 2.7
7.	Sustainability. In the short and long term, clinically and financially.	Financial analysis and Organisational integration. Section 2.9.1
8.	Whole system fit. To deliver whole health economy effectiveness and contribute to wider health system improvements.	Section 2.4

9.3 DH CHILDREN'S SERVICES REQUIREMENTS

Submitted to NHS London prior to stage one approval

9.4 DH PUBLIC HEALTH REQUIREMENTS

Submitted to NHS London prior to stage one approval.

10. EXTERNAL REVIEW AND ENGAGEMENT

10.1 ACTIONS ARISING FROM DUE DILIGENCE

Further work to be completed on this section

10.2 CO-OPERATION AND COMPETITION PANEL REMEDIES

Approved for the fast track approach with CCP.

10.3 GP COMMISSIONER INVOLVEMENT

Submitted to NHS London prior to stage one approval.

10.4 PUBLIC AND PATIENT INVOLVEMENT

LINKS representatives invited to sit on the Programme Board.

10.5 LOCAL AUTHORITY INVOLVEMENT

Formal discussions to take place with Overview and Scrutiny Committee in November/December 2010. Informal discussions have previously taken place.

Executive summary

Summary Financials

DRAFT

The Trust is not projecting a gap under its base case, with EBITDA and surpluses projected to increase slightly across the forecast period. This is predominantly driven by assumed activity growth of 3% per annum and CIP targets of 4% per annum

The projections assume the acquisition of community services from Haringey and Islington from 1 April 2011

Activity growth of 3% is significantly below historical levels of between 6-9% and CIP savings of 4% per annum may be difficult to deliver recurrently given the scale of the challenge

The Trust has considered the risk of unfunded activity growth and additional non-achievement of CIP targets in its downside case

Summary Financials - FY08 to FY16

£m	Actual FY08	Actual FY09	Actual FY10	Outturn FY11	Forecast FY12	Forecast FY13	Forecast FY14	Forecast FY15	Forecast FY16
Total Income	**153.3**	**166.0**	**176.9**	**181.5**	**271.2**	**268.5**	**268.1**	**269.2**	**270.4**
Total Expenditure	(143.4)	(162.7)	(164.0)	(166.0)	(254.3)	(251.4)	(260.7)	(260.1)	(249.6)
EBITDA	9.9	13.3	12.8	15.6	16.9	17.1	17.3	19.1	20.8
Reported Surplus/(Deficit)	**1.4**	**(1.0)**	**(5.2)**	**2.2**	**3.0**	**3.0**	**3.0**	**4.7**	**5.7**
Normalised Surplus/(Deficit) ← See Appendix 2	**3.0**	**(5.9)**	**2.1**	**(0.5)**	**1.5**	**2.2**	**3.0**	**4.7**	**5.7**
Cash inflow/(outflow)		(0.2)	(1.7)	6.5	2.7	3.6	4.6	2.8	3.3
Total assets employed	111.3	100.7	86.0	88.1	91.0	93.9	96.7	101.4	107.0
Memo									
FRR	n/a	n/a	n/a	2	3	4	4	4	4
CIPs as % of income	*5.6%*	*3.0%*	*3.6%*	*6.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*

Note: FY08 is under UK GAAP. Other years are under IFRS
Source: Management Information; Whittington LTFM v7; Integrated Business Plan

The Trust incurred non-recurrent impairments and the impact of IFRS in FY09 and FY10

Overview

- Total income and expenditure is forecast to increase significantly in FY12 as the Trust has assumed that it will be successful in hosting the community services of NHS Haringey and NHS Islington
- The Trust has applied a prudent assumption with respect to community services, assuming that efficiency savings delivered from the community services are equally offset by cost pressures, thereby delivering a flat surplus of £1.6 million across the forecast period

Income

- The Trust has assumed that elective, non-elective and outpatient activity will increase at 3% for all specialities across the forecast period, reflecting an underlying assumption of 1.5% market share growth and 1.5% population growth
- In addition, the Trust has taken account of known developments in the local health economy, such as the transfer of 33,000 outpatient attendances into a polysystem model in Haringey from FY12 onwards and the removal of 45% of emergency attendances to an Urgent Care Centre
- The assumed 3% growth across the forecast period is significantly below historical levels of between 6% and 9% per annum, but Management believe that this is a prudent view given their knowledge of commissioning intentions and the drive towards care in the community
- The Trust has informed us that this 3% growth has been based upon discussions with commissioners across the NCL sector, including the NCL Acute Commissioning Vehicle which has acted as the Trust's lead commissioner since 2009. However, although the detailed assumptions and projections have not been shared with commissioners, the Trust has shared an earlier version with commissioners showing 2% activity growth

Income (continued)

- There is a risk that commissioner demand management schemes may continue to under perform, resulting in activity growth in excess of the 3% assumed across the forecast period, which the Trust may have to deliver within its current funding envelop given the current financial pressures on the local health economy
- Tariff and non tariff deflation has been assumed at (1.1)% per annum, in line with NHS London planning assumption (assuming RPI of 2.9% less 4% efficiency savings so that there is no loss of 'real' income)
- In addition to this deflation, reduced levels of Market Forces Factor ('MFF') and Education & Training income broadly offset increased income from activity, resulting in stable levels of total income from FY12 onwards

Expenditure

- The Trust has applied the NHS London Planning assumptions with respect to pay awards of 1% per annum in FY12 and FY13 and non-pay inflation of 2.9%, as well as building in additional allowance for unknown cost pressures across the forecast period
- The Trust has assumed CIPs of 4% per annum, in line with the efficiency savings of NHS London and in excess of CIPs delivered historically. There is risk surrounding the timing and delivery of these schemes given the size of the required savings and the scale of the challenge
- Nevertheless, we note that Monitor has traditionally expected CIPs in the region of 5%, which the Trust should factor into its planning assumptions as it progresses its FT application
- Schemes are in place for FY11 and the Trust has identified the broad themes for savings across the forecast period. However, detailed plans to support savings in FY12 onwards are currently under development

Financial Risk Rating

The Trust is projecting a FRR of 4 under both the base case and downside case, driven by increasing EBITDA and Surpluses

The projected FRRs under both the base case and downside case (after mitigations) indicate that the Trust would be deemed to be financially viable by Monitor

However, the surpluses and FRR under the mitigated case are predicated on the delivery of significant efficiency savings and some extreme measures with respect to limiting pay awards, which the Trust may find challenging to deliver

Although it is unlikely that all of the downside risks were to impact in aggregate, the Trust may potentially address any gap in its projections by collaborative working or merger as part of the Tripartite work

Financial Risk Rating

	FY11 Outturn	FY12 Forecast	FY13 Forecast	FY14 Forecast	FY15 Forecast	FY16 Forecast
Base case						
Net Surplus/(deficit)	2.2	3.0	3.0	3.0	4.7	5.7
Cash balance at end	6.7	9.4	13.0	17.6	20.2	23.6
Risk rating	2	3	4	4	4	4
Downside less mitigations						
Net Surplus/(deficit)	2.2	7.9	8.3	10.0	10.3	9.9
Cash balance at end	6.7	14.2	23.2	33.8	42.1	49.6
Risk rating	2	4	4	4	4	4

Source: Management Information; Integrated Business Plan

The Trust is projecting an FRR of 4 from FY13 onwards under the base case

The Trust is projecting an FRR of 4 from FY12 onwards under the downside case

Base case

- The Trust is projecting that its overall FRR will increase from a 2 in FY11 outturn to a 3 in FY12 and then to a 4 from FY13 onwards
- This is predominantly caused by:
  - increasing EBITDA and I&E margins, driven by assumed delivery of recurrent CIPs of 4% per annum in each year across the forecast period; and
  - an increasing liquidity ratio, arising as a result of growing cash balances that have been generated from increasingly efficient operations across the forecast period

Downside case less mitigations

- As with the base case, the Trust is also projecting that its overall FRR under the downside case (after mitigations) will increase from a 2 in FY11 to a 4 from FY12 onwards
- While the Trust has identified a number of risks and sensitivities to the projections, it has also identified some mitigating actions that management believe could be implemented to more than offset the impact of any downside risk
- Both the sensitivities and mitigating actions are set out on pages [14] and [15]
- However, the most significant sensitivities that the Trust has considered are:
  - Unfunded activity growth or 'flat cash'
  - Non-achievement of CIPs
  - Further unfunded cost pressures; and
  - Loss of income from re-admissions no longer being chargeable