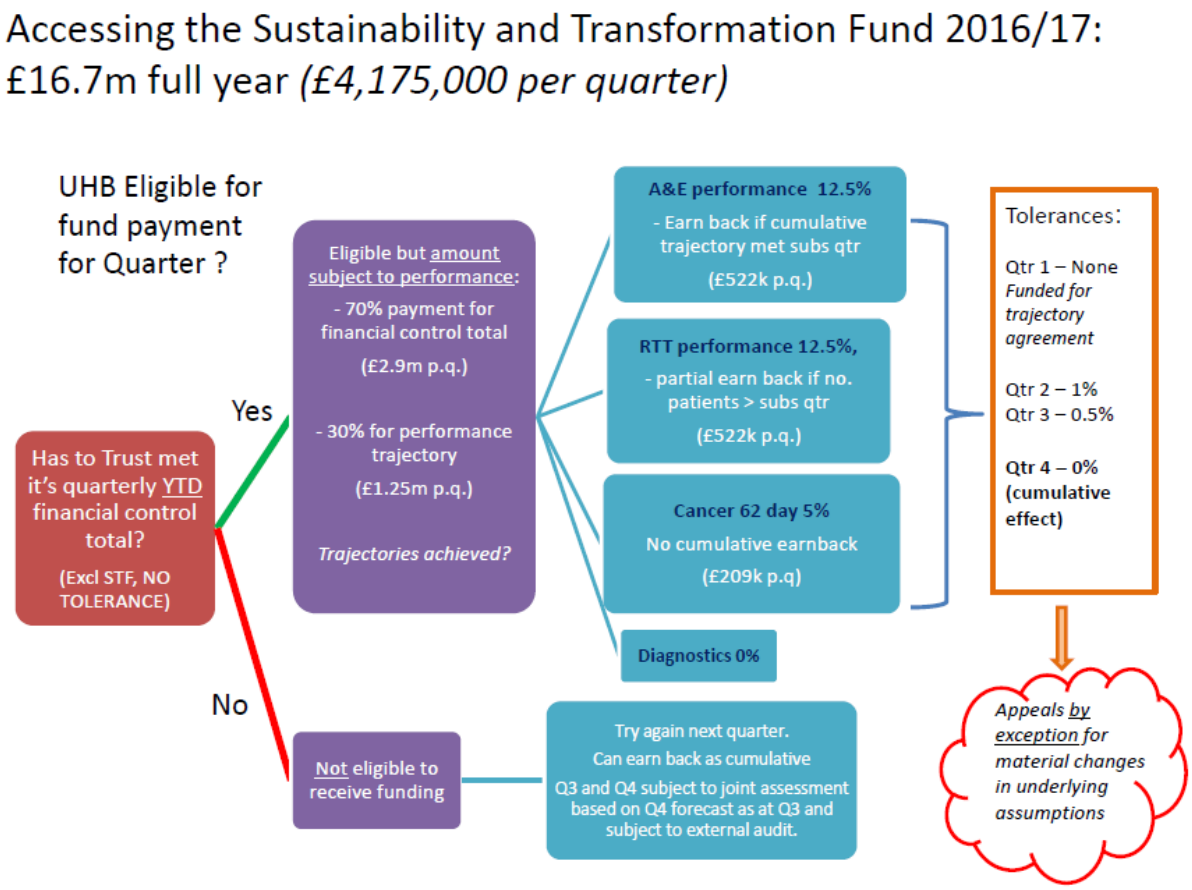
Appendix B – Sustainability & Transformation Fund Trajectories

The following flow chart describes how the STF is accessed each quarter:



There are 3 STF trajectories (now that the diagnostic 6 week wait trajectory has been removed). Performance to date is outlined below.

The Trust has already met the criteria for payment in Q1 as a result of agreeing the STF trajectories with the commissioner.

Achievement of the improvement trajectories is dependent upon a number of assumptions, as described below. Assumptions in bold text have changed or not been achieved and will form grounds for an appeal when access to the fund for Quarter 2 is submitted.

1. A&E 4 hour wait

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Plan	92.1%	94.5%	91.7%	91.9%	93.2%	93.2%	92.2%	92.5%	94.6%	94.6%	90.8%	93.3%
Actual	86.8%	81.9%	85.5%	86.5%	81.5%	81.7%						
12 hr trolley waits	0	0	2*	1*	0	0						

Underlying assumptions:

a) Emergency admissions do not exceed 29% of daily attendances.
b) There are no significant deviations in A&E attendance seasonal profiles (as seen in 2015/16).
c) Growth in daily/monthly A&E attendances does not exceed the 4.9% modelled.
d) CCG owned demand management schemes are delivered on time and in full.
e) No inpatient beds are closed due to infection outbreak or other unforeseen problems.
f) No community health or social care beds are closed.
g) No reductions in re-ablement capacity commissioned from the independent sector for any reason.
h) There are no reductions in social care provision due to budget constraints that result in delay to patient discharge.
i) There is no reduction of capacity in the RAID or Psychiatric Decision Unit Service. *Any long waits for patients requiring an offsite mental health inpatient bed are outside of the Trust's influence or control.
j) Length of stay improvements across the Trust achieved in 2015/16 are maintained.
k) Overall % of delayed transfer of care beds occupied does not exceed 2.5% in the October to March period.

2. 18 week RTT (Unfinished)

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Plan	92.22%	92.22%	92.30%	92.22%	92.21%	92.44%	92.60%	92.28%	92.28%	92.28%	92.18%	92.31%
Actual	93.3%	93.1%	92.4%	92.5%	92.1%	92.1%						
52 week waits	0	0	0	0	0	0						

Underlying assumptions:

a) Growth in demand in 16/17 does not exceed 15/16 outturn.
b) Neurosurgery (spines): Assumption that the backlog stops growing from July as a result of commissioning of an appropriate back pain pathway (pathfinder model).
c) Ophthalmology (neuro-ophthalmology): Assumption that growth in backlog continues at a rate of 20 patients per month until November when additional posts are recruited to and available. Requires business case to be supported by commissioners.

3. Cancer 62 Day Standard

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Plan	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Actual	80.3%	80.1%	80.1%	81.7%	71.2%							

Underlying assumptions:

a) To deliver 85% UHB have a tolerance of 10 breaches. This trajectory assumes that late referrals in excess of 5 a month will not count as breaches.

b). There will be no adverse impact from the *breach allocation policy when implemented compared to original modelling assumptions. Original assumptions work on the basis that any breach incurred as a result of a tertiary referral over day 38 is passed back to the referring Trust. Any breach incurred as a result of a tertiary referral prior to day 38 is a shared breach (0.5 / 0.5).

c) **The trajectory is based on a flat rate of 90 treatments per month using the current backlog of patients on the cancer PTL as a baseline**, with an expected improvement in in-house treatments from April onwards and an improvement in tertiary breaches from October 2016 onwards.

d) The trajectory does not take into account activity lost through additional doctors' strikes.

e) It does not take into account any major service disruptions. These have previously had a significant impact.

f) It does not take into account any increases in activity over and above Annual Plan agreed activity e.g. changes to NICE guidance that may put delivery at risk.

* Whilst the breach allocation policy was circulated by NHS England and NHS Improvement in early April, Trust analysis/impact assessment suggests it will deliver no material improvement on performance. This is due to the introduction of a requirement for all patients referred after day 38 to receive their first treatment within 24 days of referral to the tertiary centre (rather than 31 days) to enable a full breach to be re-allocated to the referring provider. The reality is that patients who are referred into the tertiary centre are often not fully worked up for clinical discussion at a MDT, for example patients do not have a complete set of diagnostic results required for MDT discussion and treatment planning. This makes the delivery of a 24 day treatment target inconsistent with the 31 day decision to treat cancer target already established.