Strategic Plan Document for 2013-14

Royal Free London NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Dominic Dodd

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	David Sloman

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Caroline Clarke

Signature

1 Strategic context and direction

1.1 Strategy and themes

The board's enduring governing objectives are:

excellent outcomes: clinical, research and teaching

excellent experience: for patients, staff and GPs

excellent value

full compliance

a strong organisation.

These objectives provide the structure for all that we do – planning and annual objectives, strategic risk management, operational delivery. They will remain through and beyond this planning period.

All staff of the Royal Free operate according to our world class care commitments, and all future staff will be expected to do so. Those commitments are:

positively welcoming

actively respectful

clearly communicating

visibly reassuring.

The underlying themes of this plan are:

-continuity of those governing objectives and world class care commitments;

-achievement in all quarters of 2013/14 of a governance rating of at least amber-red (recognising that the lower *Clostridium difficile* infection targets will be genuinely hard to achieve, and that a larger than usual number of over 18 weeks patients will need to be treated), concluding with a quarter 4 rating of amber-green; and a continuity of services risk rating in all quarters of 4;

-an ambitious but achievable QIPP programme for the three years;

-an objectively prioritised and justified investment programme designed to further our strategic plans;

-improvement in productivity; and

-working together with the new commissioners to address health economy wide challenges.

The investments that we plan with our partners in the three years ahead are explicitly intended to further our objectives. A remodelled and expanded accident and emergency department with associated assessment facilities (and additional consultants) will enable the Royal Free to deliver best clinical practice in response to the changing patterns of emergency demand. The first phase of the Institute of Immunity and Transplantation will open in year 1 of this plan, but by year 3 we expect to be far advanced in the planning of the major second phase together with UCL, the Royal Free Charity and other partners, this development enormously strengthening our research base and our patients' access to the most effective of the latest treatments. The planned investigation and treatment unit will improve the experience for large numbers of

patients, whilst giving us improved clinical operational efficiency. Thus in those three developments alone our governing objectives will be furthered.

1.2 The trust's strategic position within the local health economy

For local services we operate mainly in the North Central London sector and the eastern part of North West London. Both Barnet and Enfield CCGs have inherited recurrent underlying deficits that may not be resolved until the latter part of, or even beyond, this planning period, whilst Camden CCG is in significant recurrent surplus, albeit well above its target allocation. Given the changes to specialised services commissioning the trust's largest single commissioner by far is now NHS England for specialised services (expected to be around 51% of NHS clinical income in 2013/14), the next largest (Barnet CCG) representing scarcely 15% thereof. Local authorities will commission less than 1% of our NHS income. Meanwhile commissioning support units are developing as agents for clusters of commissioners, although it is not yet clear where their operating boundaries will lie.

At present the local commissioners are planning variably for growth in our contract in financial terms within an average of about 0.75% (but Barnet's figure is 1.25%) in 2013/14. Population growth in Barnet will continue to be significant with more large residential developments in or close to the Royal Free's catchment area, but the 2011 census and demographic projections show that Enfield also has a fast growing population. Patient demand from east Brent is likely to continue to increase due to a steady population growth of 1.1% per annum, whilst the strategic changes in north west London hospital services are being planned in collaboration with us. We are currently working with the new commissioners on their longer term growth (population size, structural demographic, and financial) assumptions.

We will maintain our analysis of the public health need in the areas we serve. For example chronic kidney disease and liver disease (especially alcohol related) will continue to increase markedly in both incidence and prevalence. The most significant structural change though is that over the coming ten years the number of people aged 85 years and over will increase in Barnet and elsewhere by over 30%. Older people already experience 8-9 years of unhealthy life, which describes for increasing numbers the challenge of dementia and other long term conditions. We know therefore that this, and other public health and sociological factors, means that the demands on the NHS pound will rise tangibly.

1.3 Threats and opportunities from changes in local commissioning intentions

The new commissioners will buy services that deliver the right outcomes in an affordable way, NHS England for example having already set out draft service specifications, implying that they will not fund services lying outside those definitions.

Our response to these system changes will include improving the patient and referrer experience through our World Class Care programme, whilst working closely to commissioners' requirements and delivering improved productivity. Our internal efficiency targets will be kept under review during the triennium in the light of both the pattern of community developments with their distinctive activity profiles and changes to contract currencies.

Specific risks in the next three years include a pause in co-ordinated commissioning as the new organisations reconcile their data and begin to work together, the uncertainty and potential complexity of the cancer commissioning system, local authority commissioning and initially uncertainty about the effects of the new tariff setting system. Above all the outcome of the forthcoming government spending review set for late June 2013 will bring risks for all commissioners, and therefore providers.

On opportunities we value, and will sustain, our strategic alignment on integrated care with local

commissioners, and will expect to benefit from that in delivering our service and financial strategy.

1.4 Collaboration, integration and patient choice

We will continue to live our reputation as a leader in integrated care (more about which is said later in this plan) and as a collaborative organisation, whilst working by the NHS Constitution's principles of patient choice and with our commissioners' market management policies.

2 Approach taken to quality (including patient safety, clinical effectiveness and patient experience)

Our focus is on excellence and we aim to provide services of the highest possible quality. This is embedded in our corporate objectives and our governing aims of delivering world class care. Our clinical and quality strategy over the next three years is based on our enduring governing objective of achieving excellent outcomes. This means that we plan to remain in the top 10% of relevant peers by maintaining our patient safety record, continuing to develop and invest in our research and research capacity and developing outcomes measures at clinical service level.

Our corporate objectives for 2013/14 supporting improving the quality of our clinical services are as follows.

To open phase 1 of the new academic Institute for Immunology and Transplantation at the Royal Free.

The creation of renal care facilities in Tottenham, and to centralise renal cancer surgery from across north and east London at the Royal Free Hospital as part of a centre for excellence in world class cancer care.

To continue to develop our World Class Care programme, with associated quantified improvement in patient and staff satisfaction.

To launch a new trust wide patient safety campaign.

To maximise compliance with both local and specialised services commissioners' extended quality CQUIN standards.

We will maintain an annual review of our quality guide which articulates what quality means for us, and how we set a culture of quality and high standards throughout the organisation. A further review of our quality governance arrangements, which will include an external review against Monitor's framework, will be carried out in 2014.

Following the government's response to the Francis Inquiry we intend to take an independent view and prioritise what is right for us, recognising that this is a rich opportunity to improve quality and compassion. We have made a commitment to staff about the World Class Care values and programme, in which our response to Francis will therefore be grounded. We plan to hold listening events with staff to consider the themes of Francis, and a similar exercise will be held with the Council of Governors. The results of the listening exercise will inform our priorities for the next phase of the World Class Care programme. We will also be working with our partners in UCLP to use the Francis report to accelerate wider scale change for patient benefit across the system.

For year 1 of this plan we have set three quality improvement objectives. These will then be developed during the planning period, the World Class Care programme in particular envisaged as continuing across all three years and beyond.

1 World Class Care

Relating to the "excellent experience" governing objective we will work to improve the quality of our administrative processes and how our staff interact with patients. We will invest in specialist programmes to support teams to set standards and expectations of each other and agree priorities for improvements.

These programmes of work have been supported by embedding our world class care values into the policies, procedures and training which we use to recruit, induct, manage and appraise our staff.

2 Continue the development of our clinical outcome measures

We will appoint an associate medical director for clinical performance whose role will be to develop the clinical outcome metrics. We will complete the publication of data for all our speciality level metrics. In 2013/14 we aim to commence the development of patient defined clinical performance metrics. We will continue the work with our academic health science partnership, UCLPartners, to develop common clinical outcome metrics that we can use to compare performance between organisations.

3 Establish a patient safety campaign

We will launch a patient safety programme which will build on the initial work we undertook in our Safer Patient Initiative project. The focus will be on those key areas of patient safety that have arisen from our analysis of clinical incidents, analysis of patient complaints, national guidance, and from discussion with our stakeholders including patients and governors. The safety campaign will complement our World Class Care programme which is aimed at improving patient and staff experience.

3 Clinical strategy (consistent with information contained within the published Quality Account)

3.1 Service strategy

Our major developments in this planning period include three from previous plans that continue, and a fourth that has recently been recommended to specialised services commissioners:

•chronic kidney disease (capital and revenue investment throughout the period, including in additional dialysis capacity to meet needs);

•critical care (investment in new ITU to be completed in mid 2013/14);

•integrated care, taking account of the demographic changes expected in this period (continuing developments jointly with partners to achieve lower cost delivery of services more convenient for patients, consistent with the commissioners' QIPPs, resulting in planned net loss of EBITDA in each year,); and

•renal cancer surgery centre for north and east London.

As the pattern of emergency demand changes we will respond with two significant developments, namely the appointment of additional accident and emergency consultants, and a major remodelling of our accident and emergency department combined with a new emergency assessment unit.

In further supporting our role in the sector as the major surgical centre, we will commission two additional main theatres at the Royal Free Hospital in 2013/14, and also increase the capacity of day surgery. This will in turn enable us to ensure that no more than the minimum number of our patients wait beyond 18 weeks for their treatment.

Growth is planned in those selected specialised services where demand is predicted to increase and where there is commissioner support. The completion of inward service transfers agreed in previous periods – the rest of specialised vascular surgery and hepatobiliary medicine – are also expected.

We will continue our programme of clinician led service line planning, aiming to have completed the process at least once for all clinical areas by the end of this planning period.

3.2 Clinical workforce strategy

A proposal has been agreed for a comprehensive review of the totality of the trust's medical workforce (across all grades and specialties) in the context of proposed changes to patient pathways, medical education and training, case mix and acuity, to the external pressures on funding (tariffs, MADEL, SIFT) and to the trust's own education strategy, and with reference to the QIPP agenda, the trust's governing objectives and the World Class Care values programme. The review is envisaged as being an integral part of the redesign of services, including skill mix reviews, and functions as both a driver and a component part of the change delivery model over the next five years. The key strands of the proposal are as follows:

•separation of acute and non acute care;

•development of a 24/7 hospital;

•development of workforce benchmarks;

•departmental/team job planning; and

•junior doctor rotas.

We will deliver a development programme for our newly appointed and reappointed clinical directors and service line leads, and will support nurse leadership development.

4 Productivity and efficiency

4.1 Overview of potential productivity and efficiency gains

Our governing objectives are embedded in the QIPP programme, particularly those related to delivering excellent outcomes, excellent experience and excellent value. The programme itself aims to deliver sustainable transformational change both internally and across the wider health and social care system. QIPP is therefore positioned as a critical enabler to the delivery of our overarching strategy.

The annual savings requirement is identified through long term financial modelling and confirmed within the organisation at least eight months prior the start of the financial year to which it relates. In line with best practice the savings target includes a contingency in case not all schemes fully deliver: the organisation is transparent about this contingency. Within divisions how the target is devolved to departments is similarly determined by the divisional management team and is usually informed by savings opportunities.

The programme uses a wide range of detailed benchmarking information to identify the greatest areas for improvement, which is then discussed extensively with front line and clinical staff. Current pathways are mapped and then new services designed around the needs of our patients, rather than around individual services or institutions. New pathways are tested and reviewed to ensure that the optimal model is

achieved. All new services or pathways are then formally evaluated to determine clinical and cost effectiveness and to provide assurance that the anticipated benefits have been realised. Formal evaluation is supported by our in-house public health team and assured by our internal auditors through an annual review of the QIPP programme.

Key features of the 2013/14 programme include productivity improvements in length of stay (the development of an elective ambulatory care model), specific work focused on emergency readmissions, theatre utilisation and cancelled operations, out-patient metrics such as the first to subsequent ratio, consultant to consultant referrals, and application of commissioner demand management programmes. There is a wide range of workforce efficiency metrics such as sickness absence management, use of temporary staffing, and the recruitment pipeline.

QIPP saving plans are embedded into budgets and savings are reported only as delivered when the value of these savings has been recurrently removed from departmental budgets and these budgets are being achieved. In addition to reporting year to date savings, a forecast of savings for the remainder of the year for each scheme is updated each month and a financial risk rating based on clear criteria is assigned to each savings projection.

4.2 CIP governance

The programme is developed using a matrix approach. The programme is predominantly driven through a bottom up approach with ideas coming from clinical divisions and corporate departments. However there are also a number of large, trust wide schemes that impact across the organisation. Each of these has an executive as the designated senior responsible officer, and project support comes from the central QIPP team.

Resources required to deliver the project are set out clearly within the project brief document and an 'invest to save' business case completed if required. These business cases are approved by the QIPP board. Large, trust wide schemes are supported centrally by the QIPP team, with two WTE service improvement managers, a programme manager and a variety of technical experts, sourced either internally or through the awarding of short term contracts. The QIPP programme management office (PMO) works with operational and corporate departments to co-ordinate delivery.

Schemes are put forward by directorates, each one led by a clinical director. Local schemes are signed off by the clinical division or corporate department, going through existing, well established divisional governance structures. The QIPP PMO provides support to every step of the process as required, but as a minimum local plans are required to pass through QIPP team validation prior to be being confirmed into the final programme.

An external review of the trust's practice was undertaken by KPMG in February 2013 against the Monitor/Audit Commission's "Delivering sustainable cost improvement programmes".

4.3 CIP profile

Detail relating to the top five QIPP schemes is attached as appendix 2. The QIPP programme for 2013/14 has a large number of transformational change programmes within it. Two such schemes are described in more detail below.

Elective ambulatory care pathways – development of an extended planned investigations and treatment unit (PITU)

We already make use of ambulatory pathways and have an existing PITU along with an out-patient

antimicrobial service. Detailed benchmarking undertaken in 2012 identified a number of specialities where length of stay was longer than expected and admission rates were higher for conditions that could be managed through an ambulatory route. This data was then analysed by large numbers of clinical staff to identify the areas where the most significant improvement could be made. Two examples of such conditions were cellulitis and pyelonephritis. Significant variation was identified in length of stay dependent on the admitting consultant and the ward location where the patient was placed. The review concluded that, if we invested in a purpose built 35 station PITU, not only would outcomes and patient experience be improved, with a resultant improvement in the use of precious clinical staff time, but also a further 11 in-patient beds could be closed. A business case was developed and approved by the board in July 2012. The unit is currently under construction and will be ready to receive patients in July 2013.

Review of patient administration and support services

The management of clinical administrative processes across the organisation has long been the subject of many patient complaints and much frustration for front line staff. We have developed a programme to review all clinical administrative processes and support systems to ensure we are supporting the needs of our patients and the people who provide and manage their care. This review will directly affect the processes, roles and working patterns for approximately 800 WTE staff, with many more staff impacted indirectly through these changes.

The following projects form part of this review :

•electronic medical records

•out-patient reception check-in kiosks

•medical transcription of out-patient letters

•remote and mobile working

•patient contact centre (appointments/admissions)

•GP communications

•admission process redesign.

A patient navigator role is being introduced, who will be a named member of staff supported by specialist administrative teams focused on ensuring that:

•the patient moves through the diagnostics, admission/out-patient and discharge process as quickly and smoothly as possible

•queries are responded to promptly

•communications between teams are effective, and

•patients are welcomed and directed through the system.

4.4 CIP enablers

The QIPP programme is one of sustainable, whole system transformation change. In addition to the ring-fenced clinical and project support time allocated to each project, we have invested in a central QIPP team, as described in section 4.2. Within that team is dedicated consultant, GP, nurse and therapy time to provide

the appropriate level of clinical leadership devoted to each aspect of the programme.

Increasingly, due to the scale of transformational change required, we have become more radical and innovative and therefore reliant on making strategic investments in infrastructure and technology. The projects described within section 4.3 are the most significant examples contained within the 2013/14 programme, but we have further schemes being developed for implementation in 2014/15 and beyond.

One such enabler is our scheme to modernise pathology services by entering into a commercial partnership with UCLH and a commercial pathology provider. This will provide the platform for us develop our NHS and academic laboratory services in a cost effective and efficient way

4.5 Quality impact of CIPs

For each project a risk assessment and quality impact assessment is undertaken. These are signed off through divisional structures, the QIPP board and by the medical and nursing directors before being validated by the independent QIPP clinical advisory group.

Risk assessments are revised on a monthly basis and act as the live risk register for the project. These are monitored locally within divisions and corporate departments with significant risks escalated to the QIPP steering group. Quality impact assessments are completed pre and post implementation and a scheme cannot proceed until both risk assessment and quality impact assessment have been signed off by the medical and nursing directors.

A suite of QIPP quality metrics is routinely reported to our board's finance and performance committee, which is chaired by a non executive director. The board receives additional assurance as to the adequacy of these assessments through the QIPP clinical advisory group. This is a group of clinicians nominated by their professional group, not involved in the development or management of the QIPP programme. The group reports formally to the board through the trust executive committee.

This process is audited annually by the trust's internal auditors.

CCGs have received our QIPP programme so that they can undertake a clinically led quality impact assessment of our main savings schemes.

5 Financial and investment strategy

5.1 Financial strategy

The financial strategy supports our governing objectives. This includes delivering excellent value and the board's stated intention that our financial performance will be in the top 10% of equivalent UK organisations. This high level performance will be delivered by continuing to engage the organisation in the financial challenges of the next three years as we develop local and specialist services.

We plan to continue to make surpluses so as to be able to reinvest in the capital infrastructure and other developments. We will hold sufficient cash to guarantee our liquidity with any additional funds being reinvested in services. QIPP targets have been set at a level to achieve these aims, with the engagement of the whole organisation to ensure coherent planning and deliverability. The continued development of service line management and planning, and patient level costing are intended to give managers and clinicians the information and tools that they need to deliver against individual service objectives.

5.2 Current financial position

In our first year as a foundation trust, we have demonstrated a continued strong financial performance (in line with our previous track record). The main features of the financial performance in 2012/13 were as follows.

- £12.2m surplus and an EBITDA of £32.6m;
- QIPP programme of £24.4m (recurrently £22.1m);
- cash of £82.7m (against a plan of £45m), mainly as a result of our main commissioners settling their debt in advance of the year end ahead of their closure;
- capital expenditure of £36.9m; and
- a financial risk rating of 4 in all quarters.

5.3 Key financial priorities and investments and how these link to our overall strategy

Financial priorities (linked to our corporate objectives) are to:

- deliver the QIPP programme (including meeting productivity targets) for 13/14, and plan the programme for 14/16;
- maintain a continuity of service risk rating of 4;
- introduce new business systems and processes to enhance control and reporting
- add value through enhanced strategic decision making
- establish a commercial model to include a pathology joint venture; and
- maximise CQUIN compliance.

5.4 Investments

We have an ambitious capital programme to deliver an estate reconfiguration which will support efficient delivery of care in a patient focused environment and enable transformational change. We continually review our capital programme to ensure projects are prioritised against our affordability. The most significant investments (some in our service developments) include:

- a modernised accident and emergency department . We are funding this partly through borrowing, which we have secured with the FTFF. We intend to draw down against this over the next two years);
- chronic disease, including renal disease;
- critical care; and
- extending theatre capacity to align with current and expected demand.