University College London Hospitals NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

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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Date	**31/05/2013**

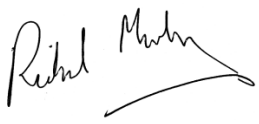
The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

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)*	**Richard Murley**

Signature 

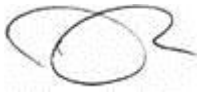
Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Sir Robert Naylor**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Richard Alexander**

Signature 

Strategic Context and Direction

University College London Hospitals NHS Foundation Trust (UCLH), situated in the heart of London, is one of the most complex NHS trusts, serving a large and diverse population. In July 2004 we were one of the first NHS trusts to achieve foundation trust status. We provide academically led acute and specialist services, both locally and to patients from throughout the United Kingdom and abroad. We balance the provision of highly rated, specialist services with providing acute services to the local populations of Camden, Islington, Barnet, Enfield, Haringey and Westminster. Our mission is to deliver top quality patient care, excellent education and world-class research.

We have a turnover of £840 million and contracts with over 70 commissioning bodies. We see over 870,000 outpatients, over 120,000 A&E attendances and admit over 150,000 patients each year.

We are one of the country's five Government funded comprehensive biomedical research centres, and were re-designated by the National Institute for Health Research as one in 2011 – meaning that new research will inform how our patients are treated. We are a founding member of UCL Partners which brings together a number of Britain's world renowned medical research centres and hospitals, including: Barts Health, Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH), Moorfields Eye Hospital NHS Foundation Trust, Queen Mary University of London, Royal Free NHS Foundation Trust, UCL (University College London), and University College London Hospitals NHS Foundation Trust. UCL Partners was officially designated as one of the UK's first academic health science centres by the Department of Health in March 2009.

In early 2012 our Board of Directors confirmed our vision: we are committed to delivering top-quality patient care, excellent education and world-class research. Underpinning this corporate vision is our commitment to continue to provide both a service to our local population alongside specialist services for the population of London and beyond.

Based on links with the Biomedical Research Centre strategy, their competitive position and their volumes of work, the Board agreed a number of strategic service development priorities and areas of partnership to focus on in the years ahead:

• **Neurosciences**: priorities include securing further neuro-oncology and neurosurgery activity, ensuring academic and clinical priorities and strengths are aligned where possible, building on the successful Wolfson bid to develop experimental neurology and increase recruitment to clinical trials, and developing plans for new capacity including a "Queens Sq @" delivery model. We have already taken on services such as brain cancer and other neurosurgical work from other trusts in the sector during 2012.

• **Cancer**: priorities include reaping the benefits of the new Cancer Centre, delivering a step change in patient experience, implementing the Proton Beam Therapy strategic development, supporting the work of the London Cancer partnership and supporting the expansion of academic cancer to compete nationally

• **Women's health**: priorities include developing plans for expansion of maternity in line with women's choice, further developing our role as a network, London and national provider of complex care for women and neonates, and supporting the cancer agenda in gynaecological cancers and breast cancer surgery.

We also highlighted the inter-relationship between our strategic service priorities and local hospital commitment: our development of specialist services requires a platform of excellence in surgery, emergency medicine and acute paediatrics. This means investing in development of surgery particularly in areas which support our objectives and ensuring that new commissioner standards for acute service quality and safety are met.

We have made good progress on pursuing our strategic aims in the last year:

- opening the new Cancer Centre and cancer partnership with Macmillan
- smooth transition of the Royal National Throat Nose and Ear Hospital into the UCLH family of hospitals, which will form the platform for the further development of Head & Neck services

- together with the Christie Foundation Trust, winning the bid to deliver proton beam therapy
- significant progress on the detail of our phase 4 development plans
- finalisation of plans to redevelop and redesign our A&E services for patients

Looking forward, however, we face a challenging environment:

- We face a real terms flat NHS budget for possibly as long as to 2020
- We have good facilities but capacity within the building is now constrained, in particular in A&E, maternity and some inpatient areas. Further growth requires a step change in investment and a major change in working practices
- The continued development of clinical networks and the reforms around specialised commissioning will drive centralisation and rationalisation of specialist services to improve quality and efficiency of services.
- The provider landscape around us is changing rapidly with plans for mergers in most sectors in London, with the outcomes of FT applications likely to trigger new partnerships and alignments.
- We have further work to do to develop our partnership relationships with the local DGH and primary care community
- Responding to the challenges set out in the Francis report.

Reconfiguration of cardiovascular and cancer services

We support the UCL Partners strategy to reconfigure cardiovascular and cancer services across North Central and North East London, concentrating specialist activity in fewer centres with frequently practising specialist teams and full facilities with the aim to improve patient outcomes and the overall quality of care.

We could see cardiovascular services from the Heart Hospital move to Bart's Health NHS Trust, creating an integrated cardiovascular system. For cancer, in April 2012 UCL Partners established an organisation with an independent board known as London Cancer. A key part of its mandate is to promote the concentration of specialist services in the sector. In early 2013 London Cancer proposed UCLH as the designated centre for prostate and bladder surgery and there have been previous decisions to centralise most of the brain cancer and teenage cancer services at UCLH as well. We may also be asked to take a leadership role in the organisation of radiotherapy, although much of this service will continue to be provided locally.

London Cancer plan to make proposals on the remaining tumour groups over the next 12-24 months. We are hopeful that a number of these will be coming to UCLH. This is the start of a long process of reconfiguration – there is still a lot of work to be done on future clinical models and funding arrangements. Ultimately it is commissioners (via the National NHS Commissioning Board) that will take the decision on services following a process of consultation.

The rationalisation of services, driven by provider reconfiguration and specialised commissioning, will require very careful **long-term capacity and capital planning**. We will be investing significant effort in understanding and modelling bed and theatre requirements over the next ten years and identifying the funding needed to deliver this ambitious programme of change. This will be challenging in the context of shifting prices and challenges on quality and efficiency over the period that we are planning for.

From review of the referral patterns and market share penetration from our local commissioners we have seen growth in elective admissions since 2010. For our 6 key CCGs we have seen market share continue to increase during 2012 compared with 2011.

The trust has taken steps to secure increased activity and market share from local GP practices by initiating a programme to improve relationships with GPs. A number of practices have been visited by the trust Chairman and one of our medical directors and we have appointed GP relationship managers to discuss issues, strategic developments and manage concerns that primary care may have with the trust. We have seen some evidence that this is supporting growth in referrals.

Demand has continued to rise for many of our specialist and tertiary services with notable increases for cancer treatments. This is due to a range of reasons, but primarily due to increased survival rates and the introduction of new treatments where we are considered to be leaders in the field. With the proposed changes in the provision of healthcare for London trusts and plans for proton beam treatment, we anticipate that we will continue to increase our cancer services activity over the coming years.

We have also seen a continued rise in maternity cases as a result of mothers' choice of hospital. We have also seen growth as a result of local demographic change and an increase in referrals for high-risk pregnancies and complex foetal monitoring.

The Trust has a number of strategic developments and transactions under consideration at present and the detail of these is included in appendix 1.

Our local commissioners are at different stages of having articulated and planned for changes in how care can be moved out of hospitals and into community / primary care settings. Our negotiations with Camden CCG are the most advanced in terms of trying to agree activity volumes and financial schedules and incentives that will support the necessary shift in care. All of our discussions with CCGs have been positive and collaborative, driven by a shared understanding of the need to improve care models and deliver savings in such a way that providers are not destabilised financially. We have established a clinical integration division within our Medicine Board and during 2013/14 will use this new dedicated resource to ensure that we deliver the opportunities for much more integrated working with local health providers. There has been some adjustment to activity plans to prepare for shifts of activity, although these have been minimal at this point in the absence of clear detail from commissioners. More ambitious adjustments may occur as part of detailed negotiations on the 2013/14 contract.

Our local commissioners have set us significant efficiency challenges around new to follow-up ratios and consultant to consultant referrals. We believe that as part of our negotiations we will convince commissioners that our consultant referrals are appropriate and will not be the source of significant efficiencies. We think there are far more opportunities to explore around the efficiency of our outpatient appointments, including the interface with diagnostic tests. The level of efficiency that we are likely to have to commit to in this area has been taken into account in our financial plans, and also provides an opportunity for us to find internal savings in support of our own QEP plans.

We have only very recently been presented with "clinical access policies" by NHS England which set out new specifications for certain specialised procedures and which list some procedures as "no longer being routinely commissioned". We are quantifying the impact of the clinical access policies and will update risk registers and forecasts when we have understood the issue in early May.

Approach taken to quality

The quality governance arrangements within UCLH ensure that key quality indicators and reports are regularly reviewed by clinical teams and by committees up to and including the Board of Directors. There are a number of committees and executive groups with specific responsibilities for aspects of the quality agenda, which report to the UCLH Quality and Safety Committee. An Executive Performance Group reviews interrelated performance across financial, operational and quality agendas. The Board of Directors receives a monthly corporate performance report (available on the UCLH website as part of the published Board papers) that includes a range of quality indicators across the three domains of patient safety, experience and clinical effectiveness.

In addition the Board receives quarterly reports in areas such as serious incidents, child safeguarding and complaints and annual reports in areas such as clinical audit. The Board is further assured by reviews undertaken by internal audit which this year has included review of clinical audit, complaints and Care Quality Commission registration arrangements.

As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each trust which is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information CQC may undertake an unplanned, responsive inspection.

In 2012/13 the CQC undertook three inspections within the Trust;

- July 2012 - 9 standards were inspected and we were found to be meeting all standards.
- July 2012 - 8 standards were inspected and the Unit was found to be meeting all standards.
- November 2012 - 8 standards were inspected and the hospital was found to be meeting the standards.

Following all CQC inspections we find their reports and observations helpful for the commentary they contain. Suggestions that CQC made include strengthening Mental Capacity Act (MCA) training and reviewing bank nurse shift cover for vacancies. Improvements the Trust has made are increasing the MCA training support and progressing an extensive nurse recruitment programme.

In addition to inspections, we have received seven queries from the CQC arising from comments made to them. On each occasion an investigation and detailed report on actions has been submitted. All responses have been accepted.

Patient safety, excellent clinical outcomes and positive patient experience have remained constant as our overarching quality objectives. Each year we assess our performance against previous quality priorities and take account of national reports and emerging themes. This year we have again evaluated our focus for the coming year and have identified a number of priorities for the coming year. Each priority comes under one of the three quality objectives.

- Patient safety
- Patient experience
- Clinical Outcomes

Clinical Strategy

In coming up with our priorities for 2013/14 we have consulted with our Quality and Safety Committee and clinical Boards. Through our Clinical Quality Review Group we have consulted with our commissioners and GP representatives and we have also taken into account the views of our governor and patient representatives. The Quality & Safety Committee on behalf of the Board approved the clinical priorities which will be reported on to the Committee regularly through the year;

The table below charts our Quality Account priorities over the last few years and demonstrates the continuity of some priorities along side newly emerging priorities;

2010/11	2011/12	2012/13	2013/14
Patient Experience			
Improve patient involvement	Improve patient experience in five CQUIN* areas	Improve patient experience in five CQUIN areas	Improve patient experience in five CQUIN areas
		Improve trust & confidence in nurses	Review planned admission process
		Improve storage for personal belongings	Improve quality of food
		Ensure availability of hand gel	Improve nursing communication with patients
	Improve out patient experience	Improve overall care rating in out patients	Improve overall care rating in outpatients
	Improve cancer patient experience	Improve cancer patient experience	Improve cancer patient experience
			Improve our end of life care
			Improve the management of pain relief
Patient Safety			
Reduce harm from falls	Reduce harm from surgical site infection & central line infections	Reduce number of falls resulting in harm	Reduce harm from falls VTE, HAPU & infection
	Assess patient VTE risk	Eliminate grade 4 Hospital Acquired Pressure Ulcers	Reduce medication omissions
		Increase VTE risk assess	Use Ward Safety Checklist on daily ward rounds
Clinical Outcomes			
Review & improve the recognition of the acutely ill	Review our unplanned readmissions	Review our unplanned readmissions	Continue to improve mortality ratio

	Improve our hospital mortality ratio	Improve our hospital mortality ratio	Develop clinical outcome measures for each specialty

In terms of the key risks to the clinical governance targets we have identified and declared two as being of concern to the board and as such have formally included them in the annual templates.

Key Risk	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
New Clostridium difficile target (39 cases) is extremely challenging	Risk that we will not meet clostridium difficile target for consecutive quarters, leading to red governance rating	Infection improvement plan with focus on further areas to improve on such as early assessment to identify risk patients, cleaning, isolation protocols and antibiotic compliance	Risk of breaching the 39 target	Monthly monitoring of supporting metrics, including antibiotic compliance, hand hygiene and time to isolation. Root cause analysis for every case.
Achievement of 95% of patients seen or discharged within 4 hours	Risk that we will not meet waiting time target for consecutive quarters, leading to red governance rating	Targets for length of stay reductions being decided to create additional capacity in UCH Tower. Some additional physical space being created in A&E department ahead of the main expansion project Commissioning of additional capacity in other locations (e.g. St Pancras) Introduction of new monitoring around pre-11am, pre-3pm and pre-7pm discharge targets to ensure adequate bed availability throughout the day	Significant risk of breaching threshold during winter period	Achieved performance level in Q4 of 2012/13. Continually monitoring volume of attendances throughout the day to identify pressures Daily validation and sign-off of breaches by ED. Escalation processes in place via the Operations Centre Accountability at monthly meetings with clinicians and commissioners.

Workforce Strategy

Our staff continue to be our most valuable asset, the cornerstone of our future success. We recognise and acknowledge the correlation between high quality human resources (HR) practices and improved patient outcomes and safety. This is underpinned by the exciting and significant work underway to enhance both the staff and patient experience, with the embedding of our UCLH values that emphasise *safety, kindness, teamwork* and *improving* at the heart of everything that we do.

The mission of the Workforce function is to:

- enable staff to deliver their very best
- care for people who care
- work in partnership, delivering focussed, evidence based workforce practices
- ensure our staff resource is maximised to deliver excellent patient care

Our Strategic Priorities for 2012 – 2015 are as follows:

- **Improve staff experience in order to improve patient experience**; building on the correlation between UCLH as an employer of choice for staff and a provider of choice for our patients, jointly lead a campaign to ensure that each and every time patients have contact with UCLH and are cared for they will have a positive experience
- **Develop a safe, supported and engaged workforce**; fully involve staff and their representatives in the significant changes ahead, enabling them to participate and act in a way that furthers the organisation's and their own goals and aspirations, in a challenging environment that is both safe and supportive
- **Simplify and embed fit for purpose workforce processes**; ensure processes, systems and information makes it easier for managers to engage in and manage workforce issues including on recruitment, temporary staffing, occupational health, staff benefits, employee relations, learning and development, pay and reward and information
- **Improve compliance and performance on key workforce metrics**; including mandatory training, appraisals, reporting and levels of sickness absence, health and safety and staff experience
- **Reduce workforce costs and improve productivity**; through removing waste, increasing productivity, appropriate skill mix and management of our pay systems, whilst improving patient outcomes, safety and experience
- **Systematise and embed leadership development**; develop and implement a systematic approach that focuses on developing a vibrant community of leaders at all levels of the organisation who are confident and competent to lead
- **Ensure that UCLH actively engages in fit for purpose education commissioning**; building on the principles of “Liberating the NHS – Developing the healthcare workforce,” ensure that UCLH plays an increasing and productive role in the proposed NHS education and workforce development system to deliver the UCLH workforce of the future

For 2013/14, the actions that underpin these strategic priorities will reflect the findings and recommendations of the Francis report, including:

- Ensuring that leaders and managers are connected with the quality of services and staff experience
- Listening to, and engaging with staff
- Wisely using intelligence, including identifying cross-cutting themes, to identify potential areas of concern and to direct where improvement should be focused

Workforce Planning at UCLH
There have been two significant enhancements to UCLH's 2013/4 Workforce Planning processes compared to previous years. Firstly, there has been greater engagement with leads within professional staff groups. In December professional leads were asked to identify and consider the key workforce trends and assumptions which impacted on their profession. This information was then assessed and considered as part of the divisional workforce planning process. Secondly, UCLH has developed a new establishment planning toolkit to enable close alignment between workforce planning and budget setting.

Workforce Plan 2013/14
As part of the 2013/14 planning round each Division and Corporate Function was asked to complete and submit the Workforce Planning Toolkit to confirm planned workforce establishment changes in 13/14. Workforce leads were informed that all changes, with a 75% or more likelihood of becoming effective, should be included in the plan.

We plan to increase (as a result of planned activity increases and service development) our workforce establishment by 214 whole-time-equivalents (wte) in 2013/14, with this increase made consistently over the year. UCLH's vacancy rate will decrease from 12.4% in March 2013 to 10.4% in April as a result of our "recruit 500" nursing recruitment campaign. We have used this vacancy rate as a basis to plan the staff in post figure which is proportional to the increase in budget, so Instead of making the assumption that each wte increase in establishment equates to an equivalent increase in staff in post we take into account current and predicated vacancy rates. (For example if a budget increases by 1 wte we assume staff in post will increase by 0.9 wte based on a 10% vacancy rate). The Trust's total staff in post figure is planned to increase by 325 from April 2013 to March 2014. Please note that the figures do not currently include the impact of the Pathology Joint Venture as at the time of writing the final number of staff transferring out of UCLH (TUPE) is to be confirmed.

In terms of the factors giving rise to the changes to establishment budgets, 48% are the result of income related activity, 41% relate to a review of skill mix and 7% relate to internal/external transfers (including TUPE transfer). It should also be noted that funding for some of the planned increases in workforce establishment budgets will be based on an assumption of increased activity and achievement of relevant QEP targets. Workforce budgets will continue to be tracked monthly via the various Workforce Performance reports.

Workforce Performance Reporting / Workforce Assurance Tool / Benchmarking
UCLH has revised its Workforce Performance Reports at corporate, clinical board and divisional levels to analyse and track key workforce metrics and Workforce Directorate performance. Alongside the workforce action tracker, these reports provide the Executive Board with assurance that key workforce risks are being appropriately monitored and managed.

UCLH has recently engaged with the National Workforce Assurance tool and the highlighted risks are monitored by the Workforce department. The focus in 2013/14 will be to identify the factors behind issues that the tool flags as 'risks' and identify the appropriate actions. The workforce department continues to use NHS I-view as a means to benchmark UCLH's skill mix at professional staff group level.

Workforce Planning Risks/Considerations
A workforce planning risk register is also in place to be able to monitor workforce planning risks going forward. Three key risks so far identified are:

1) There is a Trust-wide objective to decrease UCLH's Nursing & Midwifery vacancy rate from 13% to 5% by March 2014. As a result of a variety of pressures there is increasing demand for nursing and midwifery staff across UCLH. Whilst there has been some growth in the substantive nursing and midwifery workforce in the past 12 months (of circa 100 whole time equivalents), and a significant increase in the number of filled shifts provided by the bank, there remains unfilled demand for nursing and midwifery staff and the 'Recruit 500' project has been designed in response to this.

2) A workforce strategy has been developed for the Emergency Department which responds to the increasing difficulty nationally in staffing Emergency Departments with the appropriate level of experienced middle grade doctors. The Trust believes that this supply problem is likely to continue,

leading to over reliance on relatively junior and/or locum doctors. The staffing strategy aims to reduce reliance on locum medical staff in order to provide continuity of senior clinical care around the clock. Development of an urgent care pathway within the emergency service is part of the department's strategy. The precise medical skill mix may need to flex slightly depending on future commissioning decisions, and the workforce strategy is therefore flexible.

3) A proposed workforce (training) plan and business case for Phase 4 Proton Beam Therapy has been produced covering all staff groups including physicists and radiation planners. The pioneering (in the UK) proton therapy centre will face a very challenging patient casemix. All clinical indications identified for proton treatments are complex, and with a very limited precedent of treatments at other centres. This is unlike the standard photon service, for which nearly all treatments have well established protocols. Such a service places extra demands on staff and it is important that they are fully equipped to tackle the challenge.

Productivity and Efficiency

The Trust's Quality, Efficiency and Productivity (QEP) programme is developed each year through our devolved structure. The process is led by Medical Directors through the three Clinical Boards, with corporate department Directors leading strands to deliver around 6% efficiency requirement in their own areas. Clinicians and Operational Managers within Divisions develop local schemes and are supported in this task by Finance, Information and Workforce specialists.
Development of the programme runs to an agreed timeline indicating an internal target to identify 50% value of schemes by end January through to 100% by end June (all values are risk-assessed values, indicative targets are used for planning purposes until the final financial plan is agreed).
We review a numbers of metrics relating to Quality, Efficiency and Productivity including those listed below

Length of stay;
Morning discharge rates;
SHMI
Bank and agency spend;
Time to recruit;
Bed occupancy
Theatre productivity
Emergency readmission rates.

CIP Governance

The QEP programme office reports progress to the QEP steering group which meets bi-monthly and is chaired by the Chief Executive. This then reports through the Executive Board to the Board of Directors.
Performance is reviewed and managed through the three Clinical Boards and Corporate Directors on a regular basis.

The Trust's approach to target-setting aims to create the right incentives to ensure that quality is not compromised – we do not apply a flat-rate target to all areas, but instead hold clinical boards to contribution margin targets to ensure that they maintain their contribution level from one year to the next. This allows the Trust to ensure it responds appropriately to, for example, tariff reductions – which are a proxy for indicating where potential efficiency savings can be identified compared to national average costs.

Through our approach to Service Line Management (with Medical Directors responsible for all elements of managing service line performance), we also ensure each area is charged (through SLR) the cost of services that they use – for example, diagnostics, theatre time and be occupancy. Again, this creates the right incentives for improving efficiency as each clinical board is charged the costs that they can influence or control.

QEP profile

The QEP PMO also provides strategic transformational support the following are the areas of focus for 2013/14

- Productive Clinical Services – Outpatient efficiency, Patient Flow, Theatre Productivity
- Workforce – Acuity based workforce reviews, Agency spend reduction plan
- Procurement – Clinical standardization, Pricing work
- Clinical Support functions
- Asset utilisation

CIP enablers

All key QEP schemes are clinically led apart from Asset Utilisation and Procurement. Clinical input to those schemes is as part of the quality assurance process when relevant savings from these Trust wide schemes are considered at individual Board level.

Investing in infrastructure to deliver efficiency opportunities is considered a key enabler. A current example of this is the current business case to support IT developments to support more efficient patient flow. This includes investment in software development and infrastructure i.e. WI-Fi and mobile devices. This is a key enabler for both the Trust wide flow initiative but also smaller Board level improvement opportunities.

Quality Impact of CIP

The QEP schemes are developed through our clinical Boards and through Corporate Directors. The Medical Directors sign off any schemes which have a direct impact on patient care delivery. All of our efficiency schemes have balancing quality measures and a monthly performance pack is produced that ensures that schemes are not impacting on quality, e.g. Los schemes also look at re-admissions data. We are also engaging with our commissioners to get their input as to the likely impact of our QEP schemes on quality at the Trust.

Financial & Investment Strategy

The Trust's financial position remained strong at the end of 2012/13, with a slightly higher than planned surplus and a healthy cash position contributing towards an overall financial risk rating of 4. It is upon this foundation of financial strength that we have developed this three year financial and investment strategy, although it is clear that we face both UCLH-specific risks and the challenges of the wider economic context – these will make this three-year planning period the toughest that we have had in recent years in terms of maintaining financial sustainability. This is reflected in the continued expectation that surpluses will be modest – the financial plan assumes a surplus of £2m in each year (excluding the anticipated charitable donation with respect to the Trust's phase 4 development in 2015/16).
Our key financial priorities and investments can be summarised as follows:

- Delivering the challenge of a further three years of significant efficiency requirements (see QEP section) – totalling an estimated £111m by year three – whilst ensuring that quality is protected and improved
- Addressing our short- and medium-term capacity constraints through investments such as reconfiguring the emergency department, providing more space for maternity services and addressing the current shortfall in acute bed capacity. These will enable us to respond to the continued increased demand for our services
- Working with partner Trusts across North and East London to reconfigure specialist services in cardiac and cancer, improving clinical quality and ensuring financial viability
- Developing the Trust's Phase 4 business case, including Proton Beam Therapy

As noted above, there are a number of key risks to the delivery of the Trust's financial strategy, the three most significant of which are described below:

- Reduction or removal of Project Diamond income – the plan assumes continuation of Project Diamond based upon the figures agreed by the steering group following detailed external analysis of the cost of delivering specialist care
- Commissioning risks – there is significant uncertainty in the medium term in general as a result of the change in commissioning organisations. This, together with the additional uncertainty caused by a delay in finalising contracts and the loss of established contracting relationships, creates a significant financial risk particular in the later years of this three-year plan
- Failure to achieve planned levels of QEP – delivery of the level of savings required in the latter part of the period covered by this plan is likely to be reliant upon service reconfiguration across London. The relative lack of progress in this area, combined with the uncertainty of the future of other local NHS Trusts, creates a real risk to delivery of QEP in years two and three of the plan

Whilst the Board is confident that the 2013/14 financial plan will be achieved, there is serious concern that if any of the three risks described above materialise this may jeopardise the ability of the Trust to deliver years two and three of the financial plan. The Trust is increasing its focus on the strategic financial future of the Trust, undertaking significant work in this area including the opportunities that are available from realignment of services across London.