The Hillingdon Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

1. Operational Plan for y/e 31 March 2015 and 2016

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

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Date	**4th April 2014**

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

Approved on behalf of the Board of Directors by:

Name *(Interim Chair)*	**James Reid**

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Shane Degaris**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Paul Wratten**

Signature

2. Executive Summary

2.1 Overview

Over the next two financial years the local health economy will continue to face a number of critical financial challenges. Primarily, these are the commissioners historic trading deficit; delivering the local commissioners ambitious out of hospital strategy whilst maintaining financial viability and the financial risks brought about by the establishment of the Better Care Fund (BCF).

The North West London Shaping a Healthier Future (SaHF) Programme, outcomes of the Mid Staffs and Keogh review and the move towards Seven Day Working are the key drivers influencing the Trust's operational and capacity plan for the next two years.

The SaHF model indicates that in the longer term (2 – 5 years) there will be a significant shift of activity from acute hospitals into the community. This will be achieved by a greater focus on preventative health interventions, developing services in the community and re-classifying hospitals into two categories "Major" or "Local". Hillingdon will remain a major hospital with an A&E department and expanded obstetric unit, and neighbouring Ealing Hospital will be reclassified as a local hospital.

To support this strategy, Hillingdon has developed an operational plan to expand capacity in obstetrics, theatres, intensive-care, emergency and acute services. The first of these will be when the new Acute Medical Unit (AMU), co-located with A&E, opens in January 2015. This co-location will facilitate better integration between hospital emergency and acute services and create an Emergency Care Department. This co-location also means that Rapid Response and the new Home Safe Community Team can be based in the same area and be able to provide seamless care pathways.

As an end-state in 2017/18, this Trust's ongoing financial viability as a SaHF major acute is achieved by the transfer of sufficient activity and consequent revenue. However, in the interim years, it will require significant financial support to be able to operate as a going concern until the approved end-state is reached. This support will also facilitate the continued close collaborative working between provider and commissioner to enable the out of hospital strategy to be delivered in a way that will preserve the Trust's long-term financial viability.

Given the nature of the Trust's estate, the investments needed to improve and maintain the highest risk areas will be a long-term process. The SaHF programme does not unfortunately resolve all of the Trust's estate infrastructure issues and one of the key considerations for the Trust Board is how further investment will be sought to ensure Trust is able to provide high quality modern health care in appropriate clinical settings.

The Trust has in 2013-14 had some significant successes in delivering a sustainable QIPP saving of 4% of turnover and growing and diversifying our income streams through a number of service developments. The Trust plans to build on these achievements by continuing to evolve and grow our service transformation programme and business development plans.

2.2 Clinical Quality

The Trust's has a refreshed Clinical Quality Strategy which will help us to achieve our vision *'To put compassionate care, safety and quality at the heart of everything we do'.* It provides a structure for delivering the clinical quality governance agenda to ensure on-going improvement in the quality and safety of patient care. It outlines the responsibilities of its staff and it is supported by our culture and values framework, CARES (Communication, Attitude, Responsibility, Equity and Safety)[1]. The Strategy provides a framework so that we

[1] http://www.thh.nhs.uk/about/values.php

can be assured that our services are safe and effective. It also builds on the local and national context of service change that so critically affects quality of care for all our patients.

Our new Strategy lays out a comprehensive list of our quality objectives going forward over the next three years, however a smaller number of key strategic quality objectives have been identified that will need greater focus with regard to our current position to ensure we improve alongside other providers within London and nationally. These are grouped under the three domains of quality as follows:

- Improving clinical effectiveness
- Improving Patient Safety
- Improving the Patient and Carer Experience

The Trust recognises that in line with emerging best practice and national quality improvement initiatives, there are several key strategic enablers that will truly support the Trust in driving forward the quality agenda and that are central to the delivery of our clinical quality strategy. These include implementing improvements in relation to the London Health Programme Emergency and Maternity Care Standards; increasing and improving our understanding of patient reports of clinical outcomes and staff views / recommendations; and review of our nurse to patient ratios.

2.3 Productivity, efficiency and CIPs

The Trust appreciates that tactical opportunities for savings are now limited and in the coming years the focus needs to be very much on internal transformation programmes with a growing emphasis on health economy opportunities specifically around integrated care. The 14/15 programme is a £9m programme made up of both single year schemes and larger transformational schemes which are planned to deliver over 2-3 years.

The Trust's Transformational priorities are focused around 6 main themes:

- 7 day working
- Ambulatory Care
- Integrated Care
- Elective Pathway Redesign
- Operational Excellence
- Accessible and Responsive Services

All QIPP projects are aligned to these Transformation priorities.

[2] www.official-documents.gov.uk/document/cm74/7432/7432.asp

2.4 Financial Summary

Revenue Statement			
Forecast 2013/14 £'000		Plan 2014/15 £'000	Plan 2015/16 £'000
116,869	Hillingdon CCG Main Contract	111,000	104,342
2,897	Hillingdon CCG Transitional Support	3,900	12,000
57,852	Other NHS Clinical Revenue	62,616	61,986
5,183	Non-NHS Clinical Revenue	5,297	5,414
21,871	Other Operating Revenue	22,263	22,784
204,672	**Total Revenue**	**205,076**	**206,526**
(129,575)	Employee Benefits	(131,100)	(131,354)
(13,113)	Drugs	(13,711)	(14,210)
(20,863)	Clinical Supplies	(20,776)	(20,353)
(26,194)	Other Operating Expenses	(25,366)	(24,964)
(189,745)	**Total Operating Expenses**	**(190,953)**	**(190,881)**
14,927	**EBITDA**	**14,123**	**15,645**
(8,074)	Depreciation	(8,298)	(9,143)
17	Interest Receivable	17	17
(1,872)	Interest Payable	(1,872)	(1,872)
(3,719)	PDC Dividend	(3,904)	(4,323)
1,279	**Surplus/(Deficit) before Exceptional Items**	**66**	**324**
33	Profit/(Loss) on the Disposal of Assets	0	0
(1,092)	Impairment	(8,121)	0
220	**Surplus/(Deficit) after Exceptional Items**	**(8,055)**	**324**

Continuity of Service Risk Rating						
Forecast 2013/14			Plan 2014/15		Plan 2015/16	
1.9	3	Capital Service Cover	1.9	3	2.0	3
(0.4)	3	Liquidity	(10.0)	2	(9.0)	2
	3.0	**Weighted Average**		**2.5**		**2.5**
	3	**Continuity of Service Risk Rating**		**3**		**3**

3. Operational Plan

3.1 The Short Term Challenge

Over the next two financial years the local health economy will continue to face a number of critical financial challenges. Primarily, these are the commissioners historic trading deficit; delivering the local commissioners ambitious out of hospital strategy whilst maintaining financial viability and the financial risks brought about by the establishment of the Better Care Fund (BCF).

HCCG Financial Position

Although HCCG ended the 2013/14 financial year with an improved financial position by way of a lower deficit, it still has a significant problem to resolve in the short-term.

Part of the historic financial issue for the CCG has been that it is under its target funding allocation. This has in part been recognised in a greater than national average growth allocation over the next two years.

Although this will further help reduce HCCG's underlying deficit, they still have a very ambitious and wide reaching QIPP plan as it relates to this Trust of £12m in 2014/15 and £8m in 2015/16. Despite the severity of the QIPP plan in 2012/13 both commissioner and provider worked collaboratively and successfully together to redesign a number of clinical pathways across the health economy and reduce inappropriate demand in a number of areas. This was achieved with a contract form and package that incentivised robust joint working. As far as possible both organisations are committed to contracting in this way over the next two financial years.

Local Commissioners Out of Hospital Strategy

As a part of the NWL sector acute reconfiguration programme, HCCG has a QIPP plan largely focussed on an out of hospital strategy. In total this FT has the largest SaHF related QIPP plan relative to turnover of any NWL provider organisation. This equates to a revenue reduction of £36m over the next four years. The vast majority of this (£32m) relates to revenue planned to be lost from activity moved out of hospital by HCCG.

As an end-state in 2017/18, this Trust's ongoing financial viability as a SaHF major acute is achieved by sufficient activity and consequent revenue transferring from Ealing Hospital.

However, in the interim years, it will require significant financial support to be able to operate as a going concern until the approved end-state is reached. This support will also facilitate the continued close collaborative working between provider and commissioner to enable the out of hospital strategy to be delivered in a way that will preserve the Trust's long-term financial viability.

This was successfully achieved in the 2013/14 contracting round and both organisations are working to achieve this again for 2014/15.

Estate issues

The Hillingdon hospital was substantially built in the 1950/60s within the prevailing design principles of space and light, but the buildings are now dated and require significant investment to bring them to current standards both of clinical care and building performance with operational buildings safe, fit for purpose, and compliant with statutory legislation.

Given the nature of the Trust’s estate, the investments needed to improve and maintain the highest risk areas will be a long-term process. The SaHF programme does not unfortunately resolve all of the Trust’s estate infrastructure issues and one of the key considerations for the Trust Board is how further investment will be sought to ensure Trust is able to provide high quality modern health care in appropriate clinical settings. Capital backlog maintenance

and infrastructure projects have been identified for the SaHF programme to a value of 17.6m from an overall schedule of over £28m risk adjusted projects.

However, the Trust has not at this point included the significant investment, circa £40m, required to repair its 1960s Tower and Podium main hospital building. This requires major updating of roofs, windows and other major building and engineering components. The next iteration of the Outline Business Case (OBC) will reference this additional capital requirement. Although there are no immediate safety concerns regarding the Tower and Podium's facade and fenestration, the poor thermal efficiency creates an uncomfortable patient environment and the aesthetics of the building are not in keeping with the public's perspective of modern day healthcare.

The Trust has no option but to continue to commit and target its limited capital resources into maintaining its old building stock, especially the Tower and Podium that dominates the site. The Trust's annual investment is routinely aimed at works that have been assessed as high risk and that for most part are determined by the need for immediate investment that could, if left undone, impact on patient safety.

Better Care Fund (BCF)

The Trust is firmly committed to closer health and social care integration through the removal of perceived barriers and constraints between agencies. Whilst the Trust fully accepts the requirement to redesign pathways to improve care for patients, the organisation is also cognisant of the fact that over the next two financial years HCCG's commitments and funding allocation in respect of the BCF has the potential to move a significant amount of additional income from this Trust. This clearly represents an additional risk to both this organisation and the local health economy's overall financial recovery although we are working closely with commissioners to manage this.

The Trust has undertaken a significant amount of work over the past year to develop stronger networks with its local providers. The Trust has formalised a number of work programmes with CNWL as its local mental health and community service provider such as the introduction of Early Supported Discharge and Rapid Response teams. We have also expanded the acute hospital support service arrangements we provide to Royal Brompton and Harefield, as well as looking to jointly redesign the cardiac pathway for Hillingdon residents. Work is underway with three other North West London Trusts to develop a regional pathology hub, with a decision due in summer 2014.

3.2 Quality Plans

3.2.1 National and local commissioning priorities

National Priorities

2013/14 saw a great deal of change in the structure of commissioning in the NHS which will further develop through 2014/15 and beyond. In April 2013 NHS England was created and took over the commissioning of Prescribed Specialised Services and of Primary Care health services in England. The publication of "A Call to Action" in July 2013 set out to target the challenges facing the NHS focusing predominantly on people living with long term conditions, increasing costs and rising expectations on quality of care.

Specialised Services commissioners have developed a 5 year strategy following this publication and whilst significant changes are not expected with regard to 2014/15 commissioning, the trust is aware of the need and intention to review and consolidate and centralise specialised services where appropriate. This is planned to ensure both the most cost effective and safe settings for care delivery, but also the most appropriate to achieve earlier prevention and earlier intervention.

Compliance for providers to the London Quality Standards is another priority. These were developed recently following the Quality and Safety Programme review and demonstrated that patients admitted as an emergency at the weekend have a significantly increased risk of dying compared to those admitted on a weekday. Reduced service provision, including fewer consultants working at weekends, is associated with higher weekend mortality rates. Consultant presence at the weekend is found to be half of what it is on weekdays across London. The quality standards aim to improve emergency pathways, which ensure that the assessment and subsequent treatment and care of patients admitted to these services as an emergency will be consultant-led, seven days a week and consistent across all providers of these services.

Better care for long term conditions is a national priority and can be achieved by the trust working closely both with other services within our own organisation and also with other providers from both public and private sectors, with the support of the Health and Wellbeing Board to ensure a seamless pathway of care in a multitude of settings. Patients with long term conditions will particularly benefit from more community based care that should result in fewer hospital visits. Another national priority for 2014/15 in the NHS is the prevention of people dying early by focusing on early diagnosis and appropriate treatment.

Local Priorities

In order to meet the demands of the local health economy the "Shaping a Healthier Future" vision was created endorsed by commissioners and providers alike. The commissioning priorities locally for NWL were considered to be the centralisation of specialised services, care closer to home and better integrated care between acute, community, social care and GPs.

Hillingdon CCG specifically want to ensure more care will to be managed outside of the acute setting including the management of long term conditions and also redirection of patients from urgent care settings. With provider and GP support, they have begun to review planned care pathways particularly around long term conditions to avoid unnecessary hospital visits and support care closer to home in either a primary care or community setting.

Hillingdon CCG would like to focus on reducing hospital admissions and readmissions, as well as getting patients home earlier with ongoing support available outside of an acute setting. During 2014/15 a model of community based support will be developed to help commissioners meet the required outcomes of reducing hospital admissions, admissions to nursing care, and supporting people to remain independent as long as possible.

3.2.2 The Trust's quality goals, as defined by our quality strategy and quality account

During 2013/14 there has been an increased focus on how we measure and monitor quality and there has been a review of the information that is received both at the Board and at its sub-committee, the Quality and Risk Committee (QRC). Whilst undertaking this work, the Trust has considered and made reference to key NHS investigations and reviews, and in particular the Francis Report, and the Keogh and Berwick reviews; this in turn has supported us in developing a new clinical quality strategy. Our new Strategy outlines the learning and recommendations from these key publications and these underpin our key aims and objectives for quality improvement. In addition, we have reviewed our current quality performance alongside national and regional quality data and referenced local feedback from both staff and patients. The analysis of these and our recent award of a 'Band 6' Trust as part of the new CQC Hospital Intelligent Monitoring Band Ratings confirm the importance of strong quality performance across a range of indicators.

The new Strategy will help us to achieve our vision *'To put compassionate care, safety and quality at the heart of everything we do'.* It provides a structure for delivering the clinical

quality governance agenda to ensure on-going improvement in the quality and safety of patient care. It outlines the responsibilities of its staff and it is supported by our culture and values framework, CARES (Communication, Attitude, Responsibility, Equity and Safety)[2]which embraces a culture that empowers staff to report incidents and raise concerns about quality in an open, blame-free working environment. The Strategy provides a framework so that we can be assured that our services are safe and effective. It also builds on the local and national context of service change that so critically affects quality of care for all our patients.

Our new Strategy lays out a comprehensive list of our quality objectives going forward over the next three years, however a smaller number of key strategic quality objectives have been identified that will need greater focus with regard to our current position to ensure we improve alongside other providers within London and nationally. These are grouped under the three domains of quality as follows:

Improving clinical effectiveness:

- **Improve Patient Reported Outcome Measures (PROMs)** – the trust will improve the key hip and knee PROM indicators to be in line with the national average and it will aim to increase the response rate to the PROM questionnaires from patients.
- **Improve the Initiation of Breastfeeding**– the trust aims to improve the uptake of breastfeeding amongst women to achieve >88% by increasing women's awareness of the value of breastfeeding and working with our GP commissioners to raise awareness across the local community.
- **Reduce Caesarean Section Rates**–the aim is to achieve a reduction which is in line with the London average through learning from the best performing trusts and reviewing our existing systems and processes.
- **Achieve Accident and Emergency Access Targets** – it is important that patients are seen as quickly as possible when they attend the A&E department. The trust aims to achieve the expected target of >95% for all types patients seen within four hours.

Improving Patient Safety:

- **Reduce mortality rates** – the trust aims to improve the Hospital Standardised Mortality Ratio (HSMR) and reduce the variation between weekend and weekday mortality rates so that it is in line with the best performing trusts in the London region.
- **Preventing avoidable deaths** – the trust aims to achieve a year on year reduction in avoidable deaths through surveillance of all specialty mortality and open Multi-Disciplinary Team mortality meetings led by a Mortality Lead. The trust will share the learning from all identified preventable deaths.
- **Reduce avoidable infections** – the trust's aim is to reduce avoidable healthcare associated infections to zero. The trust has a robust annual action plan based on its three year infection prevention and control strategy. The trust will aim to achieve the targets set by its regulator Monitor for MRSA & Clostridium Difficile infections for each forthcoming year.
- **Patient Safety Thermometer (PST) and Delivering Harm Free Care** - the trust aims to reduce the level of hospital acquired harms as measured by the PST and reduce the overall incidence of pressure ulcers and patient falls with harm. The aim is to ensure that at least 95% of patients consistently receive harm free care in line with national targets.

[2]http://www.thh.nhs.uk/about/values.php

[2] www.official-documents.gov.uk/document/cm74/7432/7432.asp

- **Implementation of the National Early Warning Scoring (NEWS) system** - implementation of the national EWS system which supports early identification of any deterioration in a patient's vital signs and medical condition is a priority for the trust. Roll out of this system across the trust will support identification of those patients who may need more intensive care and treatment at the earliest stage. The trust needs to ensure it is in line with this national initiative and with other acute care providers.
- **Reduce the number of patient safety incidents that are graded as moderate and severe** – learning from incidents in relation to patient safety is an important part of our clinical governance process. Ensuring staff report incidents and near misses helps us in taking actions to prevent reoccurrence and to avoid more serious incidents from occurring. Organisations that report fewer incidents may have a weaker and less effective safety culture. Our aim is to ensure we are above the national average in incident reporting, particularly for no/low harm incidents.

Improving the Patient and Carer Experience

- **Achieve year-on-year improvement in the National Patient Survey** – our aim is to ensure we are amongst the best performing trusts for the patient experience of care. We particularly want to ensure that we achieve high scores in relation to how patients rate their care overall and how responsive we have been in meeting their needs in relation to communication and compassion.
- **Improve our Management of Patient Complaints** – responding effectively to patient feedback is a key priority for our staff. We want to ensure that we learn from our patients and their families with regard to their experience of care they have received and where we can make improvements to ensure patients and their families receive the highest possible quality of care. We aim to ensure that >90% of complaints are responded to within agreed time frames and that there is effective resolution at the earliest stage.
- **Improve Patient Experience of the Outpatient Pathway**– the trust aims to ensure that the patient experience is positive for all patients attending the hospital; improving arrangements in relation to outpatient appointments is a key priority. This will assist the trust to deliver a more efficient and effective service, which will reduce cancellations and non-attendances and improve communication with patients, GPs and other healthcare providers.
- **Improve Patient Experience of Leaving Hospital** – the trust has already undertaken work on improving the inpatient care pathway and reducing the length of stay in hospital for patients in response to the results of the National Patient Survey. The trust aims to ensure that the discharge from hospital process is managed efficiently and effectively and that patients report this via the National Patient Survey and via the Friends and Family Test survey. Improved integrated pathways of care and working closely with our health and social care partners will support an improved experience for patients in them returning to primary care at the earliest opportunity. We will aim to evidence the introduction of integrated care pathways, improved communication between the trust and our partners and reduction in length of stay.

The Trust recognises that in line with emerging best practice and national quality improvement initiatives, there are several key strategic enablers that will truly support the Trust in driving forward the quality agenda and that are central to the delivery of our clinical quality strategy. These include implementing improvements in relation to the London Health Programme Emergency and Maternity Care Standards; increasing and improving our understanding of patient reports of clinical outcomes and staff views / recommendations; and review of our nurse to patient ratios.

In addition, the Trust recognises the need to ensure that we have key elements well organised and resourced: such as accurate data collection and analysis and more effective coordination; interpretation and presentation of quality information at all levels of the

organisation; effective risk management and clinical audit; systematic processes for assessing the impact of service changes on quality; strong clinical leadership; and greater patient involvement in improving services. These are outlined in our new clinical quality strategy.

The Trust needs to ensure that it is modernising and reconfiguring the hospital and its facilities to enhance clinical quality and the patient experience and that we use capital resources to best effect and that clinical staff are at the forefront of environmental improvement. This is particularly relevant in ensuring that emergency and ambulatory care pathways can be supported in the right environment of care, and that our dementia strategy which includes improved care surroundings is driven forward, ensuring the hospital becomes truly dementia friendly. There is extensive work already underway in supporting this aim in the building of a new Acute Medical Unit to support the emergency care pathway, and the refurbishment of an older people's ward to ensure it is dementia friendly as a result of a successful Department of Health funding bid. As one of 15 pilot sites nationally to support research and learning in this area; this will very much help the Trust consider dementia friendly refurbishment to any of its facilities in the future.

The Trust, identified under Shaping a Healthier Future (SaHF) as one of the five major hospitals in NW London providing a full range of 24/7 emergency care in the region, recognises the strategic challenges that this brings. The programme is based on implementing the London Health Programmes (LHP) standards for Emergency Care across all the major hospitals in NW London and in all specialties that take part in the provision of this service. The programme also places an emphasis on the provision of a wider range of out-of-hours primary / urgent care and out of hospital care; this will involve reducing lengths of stay and reducing hospital readmission rates. The latter in particular continues to be above the national average. The Trust is working closely with its GP commissioners and other providers to ensure that across the healthcare community patient care is provided in the right place at the right time.

The following five priorities identified in the "Look forward" section of the 2013-14 Quality Report, complement the themes outlined above:

Priority 1 – Continuing with the First Contact Project
The Accessible and Responsive Services QIPP scheme has highlighted areas in appointment management (listed below) that would benefit from further service redesign.

- The introduction of information software that assists in planning outpatient capacity to meet the referral demand. The go live date for this tool is March 2014.
- Management of appointment cancellations will move from the PAS team to the outpatient appointment centre (OAC). This will ensure greater scrutiny of appointment cancellations and challenge to specialties.
- Correspondence about appointments will be centralised to improve the accuracy and consistency of information given to patients.

Priority 2 – Continuing with the Improving Inpatient Care Project
Key work streams under this title include:

- Reducing re-admissions
- Admission avoidance/ambulatory care pathway work developing shared pathways of care
- Early Supported Discharge workstreams
- Leaving Hospital Improvement Project, including discharge from A&E.

These areas have been identified from a variety of sources and they aim to work with our local health and social care partners in delivering integrated care pathways and more care in the community.

Priority 3 – Improving the safety In Emergency and Maternity Care
This includes delivering the London Health Programme Emergency and Maternity Care Standards to support 7 day working for Emergency Care, earlier senior decision-making and a reduction in mortality and morbidity.

Priority 4 – Introducing patient care bundles
This includes the use of care bundles to reduce variation in care delivered to patients, reduce mortality rates and improve clinical outcomes in some clinical diagnoses. It also supports improved ambulatory care pathways which will ensure reduced length of stay.

Priority 5 – Improve responsiveness to patient need
This includes reviewing the current sources of patient feedback and looking at more innovative approaches to learning from patients and their families/carers, including a complaints review. It also covers examining Care at the Bedside which includes increasing staffing ratios in selected areas and improving staff attitude.

3.2.3 Existing quality concerns (CQC or other) and plans to address them

Concern	Action
1. Minor concerns in relation to Infection Prevention and Control (CQC)	Delivery of the agreed action plan post CQC inspection of November 2013.
2. Minor concerns in relation to the Estate (CQC)	Delivery of the agreed action plan post CQC inspection of November 2013. Delivery of the Trust's Estate Strategy and action plan.
3. Moderate concern about nurse/midwifery staffing levels (CQC)	Delivery of the agreed action plan post CQC inspection of November 2013. Current review of nurse to patient ratios and skill mix with agreed safer staffing assurance framework and monthly board reporting.
4. LHP Emergency Care standards for Medicine and Surgery	Focus on early consultant decision making (within 12 hours of admission) seven days per week. Clear communication (merged hospital notes, timely GP information). Need for seven day per week clinical support services (e.g. therapies, pharmacy, social care, radiology reporting).
5. LHP standards for Paediatrics and Maternity	In Maternity focus on midwifery ratios and 1:1 care in labour, enhanced hours of labour ward consultant presence. In Paediatrics, continue to focus on adequate numbers of trained paediatric nurses at all times in A&E and safe staffing levels in response to higher acuity patient needs on the Paediatric ward, and on early consultant decision making (within 12 hours of admission) seven days per week.
6. Weekend mortality rates	Delivery of the Trust's mortality action plan to reduce weekend mortality in line with regional average with review of outliers by speciality.

3.2.4 Key quality risks inherent in the plan and how these will be managed

Key quality risks	Plans to manage
Failure to achieve 95% A&E target	A number of initiatives are planned to improve performance: • Additional medical and nursing staff in A&E out of hours • Additional supernumerary co-ordinator on duty in A&E out of hours • Planned expansion to ambulatory care pathways for non-elective patients will increase the throughput of patients being pulled through directly to our Emergency Assessment Unit. • Participate in the NWL pioneer whole systems plan. • Work collaboratively with HCCG, Hillingdon borough council, Hillingdon Community Health and the third sector to implement the requirements of the integration transformation agenda and to ensure that admissions to hospital are avoided where possible, and that time spent in the department is reduced. • To continue to identify patients who are regular attenders and with consent will review care plans on an individual basis using a multi- agency approach.
Failure to meet MRSA or C diff target	• Delivery of the Infection Prevention & Control (IP&C) strategy. • Delivery of 2014/15 Healthcare Associated Infection Action (HCAI) plan, including implementing actions from RCA learning. • Implementing '*Start Smart, Then Focus'* antimicrobial prescribing action plan.
Reducing moderate to severe incidents (SIs)	• Ensure this is a key part of Divisional Governance forums, highlighting key themes, identifying learning opportunities and developing action plans and monitoring, reporting to Clinical Governance Committee and QRC. • Develop an improved culture in relation to actions taken on no/low harm incidents which have potential for increased severity.
Failure to reduce weekend Hospital Standardised Mortality Ratios (HSMR)	• Improve co-morbidity coding, working with clinical and coding teams. • Identify specialties with high HSMR and understand factors with implementation of clinical changes (e.g. bundles of care) as appropriate. • Learn lessons from audit and ensure there is a robust action plan that is monitored via the QRC. • Ensure actions are implemented in accordance with LHP standards, e.g. senior clinician review at weekends.
Failure to implement key Francis Report recommendations	• Deliver the Trusts' Francis action plan. Report to QRC on progress. • Raise awareness of the Trust's refreshed clinical quality strategy via the communication and engagement action plan. Report to QRC on progress. • Ensure the quality indicators identified in the clinical quality strategy are detailed in divisional business plans. • Further embed Trust culture and values (CARES: Culture, Attitude, Responsibility, Equity, Safety) framework with clear

Key quality risks	Plans to manage
	measurable outcomes • Further publicise “whistleblowing” policy and reinforce open, no blame culture. • Explore further opportunities for listening to and engaging with staff, via CEO briefings and divisional briefings. • Introduce Schwartz Rounds. • Deliver improved performance in quality indicators within the Patient Safety Thermometer. • Deliver the new Nursing and Midwifery Quality Assurance Framework.
Failure to meet adequate levels of staffing implied in Francis Report due to financial & trained staff constraints	• Working with operational divisions to develop robust plans to pilot the supervisory senior sister’s role. • Skill mix and staffing ratios are currently under review taking best practice guidance and acuity and dependency assessments into consideration; these are to be reported monthly to Board with regard to planned and actual numbers and staffing numbers to be displayed daily in clinical areas. • A detailed staffing report to be presented to the Board twice a year (as a minimum) or when there is significant service change using the appropriate best practice guidance and evidence-based tools.
Failure to reduce the number of in-patient falls and hospital acquired pressure ulcers as measured in the Patient safety Thermometer	• Reduction targets set for each ward and to be reviewed for 2014/15 and included on nursing quality dashboard; overall Trust target is included on Trust Board quality dashboard. • Exception report to be provided as part of quality report to Trust board monthly. • Incidence of falls/pressure ulcers to continue to be monitored at nursing performance meetings. • Falls/pressure ulcer reduction action plan to be monitored at Clinical Governance Committee and reported to Quality and Risk Committee.
Complaints Management: Failure to achieve target response rate of >90%. Failure to transform complaints handling to ensure there is improved responsiveness and organisational learning.	• Implement recommendations from ‘*Designing Good Together: Transforming Hospital Complaint Handling’* (2013) • Ensure open culture, shared learning, continuous improvement and for complaints to be managed in a more timely and responsive way. • Complaints action plans to be robustly monitored by divisional governance boards, actions and learning to be reported at Clinical Governance Committee. • Complaints/PALS performance report to be monitored by Quality and Risk Committee and exception report to be provided to Trust board alongside quality dashboard, • Learning to be shared more widely across the organisation in ‘Team Brief’.

3.2.5 Board assurance on the quality of services and safeguarding patient safety

The Board monitors quality, and achieves the necessary assurance, through the following processes:

- There is monthly reporting to the Board via the quality and performance report; this highlights quality issues and improvement through narrative information and performance indicators. Each quarter the board's sub-committee, the Quality and Risk Committee (QRC) receives a much larger Quality and Patient Safety Report; this includes information on the key quality indicators that feature on the Trust's quality dashboard in much greater detail and it also includes items that are not included in the monthly quality performance reports, for example information from NHS Choices. Any external / peer reviews, and a summary of performance against KPIs in the Annual Quality Report "Look forward" section are also reported at this committee with escalation to the Board where required.
- Serious incidents have a named executive lead and panel reports are presented to the Board with the resulting actions reviewed each month until complete. Root cause analysis is used for all serious investigations and forms the basis of the report to the Board and the formulation of action plans.
- The QRC oversees a wider range of quality indicators, now with much greater granularity including mortality indicators reviewing any variance by day of the week and performance in relation to national and regional averages, nursing quality indicators by ward and outcomes of clinical audit with presentation of action plans by clinical leads. It also reviews a detailed quarterly overview of complaints in terms of themes and lessons learned and actions taken; claims and litigation data; incidents numbers, severity and themes by clinical division and medium and high risks and actions being taken to address. Regular reports to the Board, including exceptions, are presented by the QRC. The QRC has recently received the Trust's new Clinical Quality Strategy and it will expect to see a robust action plan with quarterly review of progress. The trust-wide action plan will feed divisional business plans which will be reviewed with the Executive Team via quarterly divisional review presentations.
- A programme of regular monthly ward visits including Board members, conducted in a structured "Observations of Care" approach. Observations involve an outside observer (a senior nurse, with no responsibility for the area being observed) and an inside observer (usually the ward sister/charge nurse) spending time in a ward/department assessing the environment of care, the quality of care being delivered, the nursing documentation, teamwork elements and patient/staff experience using a structured tool. Feedback is given to the team following the assessment and the outside observers meet together after the observation to debrief and capture any themes that emerge across a number of wards/departments. Board members participate in this observation which gives them the opportunity to talk to staff and patients about their experience.
- The Director of Nursing and Patient Experience has introduced Clinical Fridays which allows the corporate nursing team and divisional senior nurses, alongside the Director of Nursing and Patient Experience, to work with clinical staff on wards and in departments to experience the environment and delivery of care, engaging with staff and patients and their carers. Any issues or concerns raised through this opportunity are escalated accordingly to the Executive Team and Trust Board, via the quality narrative within the Quality and Performance report and Putting People First report
- There is a robust framework to ensure that all service changes have a Quality Impact Assessment (QIA) which is then reviewed by the Medical Director; any schemes where there are quality concerns are reviewed at the multi-professional Clinical Assurance Panel (CAP), with the project leads presenting the scheme and the actions being taken to mitigate any risks to quality associated with the scheme. All complex service

changes (e.g. all cross divisional schemes) will have scrutiny by the CAP as described below in section D, chaired by the Medical Director, and also reviewed at the monthly Quality, Innovation, Productivity and Prevention (QIPP) meeting. The Transformation Committee (a Board Committee comprising the Chief Executive, Chair, and Medical and Nursing Directors) reviews the QIPP programme.

- Listening to Patients/Governors: it is important that there is a range of opportunities to support patients in providing feedback and raising their concerns. This is welcomed by the Trust as a learning organisation which is always striving for quality improvement. Patients can complete local patient experience surveys, provide feedback via the Trust website, via NHS Choices, in person directly to department managers and matrons or via the PALS/Complaints offices. There is also opportunity for patients and members of the public to attend the Trust's People in Partnership (PiP) meetings which are held bi-monthly, and there are also specialty-based focus and support groups, where again patient feedback can be obtained. The Board now receives patient stories as part of understanding the patient experience; this ensures that the voice of the patient and their families/carers is heard first hand by board members; stories are captured directly from patients via 1:1 interviews and via complaints and PALS feedback. The Board also receives information on patient experience as a result of the Friends and Family Test and our local patient experience survey. The Trust's Experience & Engagement Group (EEG) has a particular role in reviewing patient feedback, ensuring that clinical divisions and support services are truly engaged and focused on the patient voice and experience. Patient experience data is reviewed in detail and action plans to improve the patient experience are presented and discussed. Governors are encouraged to feedback to the Trust comments from the members on the Trust's services. The EEG includes Governors, and the quarterly Council of Governors meetings receive information on the quality of the Trust's services, including a report on patient experience and a quality & operational performance report.

3.2.6 What our quality plans mean for our workforce

With the publication of the *Francis Report* (2013) together with the launch of the Chief Nursing Officer's national strategy, *Compassion in Practice* (2012) and *Developing the Culture of Compassionate Care* (2013) the Trust has considered the significant implications of these publications on our workforce. Our quality plans include the need to develop our workforce to embrace the recommendations outlined and in particular the leadership capability at every level of the organisation ensuring there is a robust leadership training and talent management programme. The Leadership 100 programme is currently underway which aims to develop the leadership capability of our senior managers; this follows the very successful Ward Advance Leadership Programme for Ward Sisters and Charge Nurses. The leadership training, along with a culture of empowerment for clinical leaders, will support an improved experience for our patients and provide clarity on the responsibilities and accountabilities that are expected from our leaders in delivering safe and effective care.

The need to reinforce our CARES values through an extensive customer care training programme has been recognised and this is currently being delivered across the organisation. This supports our CARES values being integrated into everyday practice by our staff, in not only delivering quality care at the bedside and in every department but also during recruitment and selection, appraisal and performance management activities.

Our new clinical quality strategy aims to ensure that there is a culture of openness, transparency and candour in the Trust's systems with strong clinical leadership, particularly in nursing to ensure there is strong representation of the patient and carer voice. Involving staff in transforming the way we deliver services and listening to their views on the improvement of clinical quality underpins our strategy. Our workforce, and particularly our clinical leaders, will be empowered to drive quality and be clear about what high quality care

looks like in all specialties, reflecting this in a coherent approach to the setting of standards of care and treatment.

The Trust recognises its responsibility in ensuring it has the right numbers of staff with the right skills to deliver a safe and effective service to its patients. The Trust is currently reviewing its front-line clinical staffing levels and in particular numbers and skill mix of the nursing workforce in line with best practice requirements and acuity and dependency assessments. There has already been a review of staffing establishments in some key areas where uplift to staffing levels on some nursing shifts was required. There will be regular and transparent reporting at ward, divisional and at board level; a reporting assurance framework has been developed and agreed. The Trust has also undertaken a six month pilot of supernumerary status for the Senior Sister/Charge Nurse role, the results of which will be presented to the Trust Board for consideration.

Our workforce will need to be adaptable and flexible in relation to the modernisation of the NHS and what this means to the delivery of services in our local area, particularly under the *'Shaping a Healthier Future'* strategy and work programme; this is outlined in our clinical quality strategy and in our action plan, working with our partners in health and social care to transform patient pathways and where patient care is delivered. We are ensuring that our clinical staff are at the forefront of this change enabling them to be innovative and deliver the most effective and efficient service to our local community and beyond.

3.2.7 Our Response to Francis, Berwick and Keogh

The Francis Report into the failings at Mid Staffordshire NHS Foundation Trust where the standard of services put patients at risk is a salutary reminder that things can go wrong when quality is not put at the heart of what we do. An intrinsic part of our clinical quality strategy over the next three years will be the implementation of the recommendations of the Francis report. The Trust has developed an action plan is response to Francis which also takes the recommendations from Keogh and Berwick into consideration. The Trust is currently reviewing the nursing and midwifery workforce, in particular to improve nursing/midwifery care at the bedside, and we will monitor the quality of care through our patient surveys, detailed and patient focussed nursing performance templates and establish further mechanisms for measuring compassionate care. The Trust has developed a series of pledges that will be embedded within the Trust and against which we will track progress and produce a public annual report discussed at the Board.

The Keogh Report measured 14 acute trusts that were persistent outliers on mortality indicators against a variety of safety indicators; this has informed our Strategy and forms an integral part of our ambition to ensure that we continue our work on reducing hospital mortality, On conducting a detailed gap analysis against the Keogh Review standards, the following was identified:

- Our mortality rates are below the national average (HSMR & SHMI)
- Pressure ulcer rates are lower than the national average over the last three years
- MRSA rates dropped significantly over the last two years but are still historically at or slightly above the national and regional average
- C diff rates have reduced dramatically over the last two years and are at below the national average
- The trust faces a significant challenge to maintain the downward trend in infections and the targets for MRSA and for C difficile will be challenging
- Reporting of incidents is at the national average
- Medical error rates per 1000 admissions is 5.88 compared to the national average of 7.7

The Keogh analysis of "Failing Trusts" also highlighted the importance of well embedded Early Warning Scoring Systems, sepsis care bundles and an effective complaints procedure;

each of these is being actively tackled by the Trust to ensure there are robust and effective processes in place. The National Early Warning Scoring (NEWS) system is currently being rolled out across the Trust, supported by extensive training and the introduction of revised documentation.

The Berwick Report clearly identifies the importance of constant vigilance, monitoring and learning to make sure our patients do not come to any kind of avoidable harm. Our clinical quality strategy clearly identifies the need to actively seek out the views of patients and staff, and work hard to build a culture of openness, honesty and support in the pursuit of patient safety. The Trust will continually aim to reduce patient harm by embracing wholeheartedly an ethic of learning. The Trust's clinical and managerial leaders will place quality of care and patient safety at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support, as recommended by Berwick.

3.2.8 Risks to delivery of key plans

Financial constraints and saving requirements which may affect the ability to drive forward change:
The Trust wants to be able to deliver services in a different way to best meet the needs of our patients with a review of patient pathways and more integrated ways of working; this may need investment in staffing and capital infrastructure, e.g. IT support. In addition, implementing improvements in relation to the London Health Programme Emergency and Maternity Care Standards to include seven day working and earlier review, presence and decision-making by senior clinicians will require investment in staffing.

Recruitment difficulties in attracting the right staff with the right values:
It is essential that we recruit the right staff and that we retain these staff and develop the aptitude and behaviours that we want to see in order to deliver improvements in quality. A robust recruitment programme and achieving a good understanding of the reasons for staff leaving the Trust will support an improved approach to staff recruitment and retention.

Lack of resources for health and social care partners to support integrated care pathways:
Trying to achieve significant financial savings plans while maintaining and improving clinical quality is a key strategic challenge for all of our health and social care partners. There is concern that a reduction in provision of key services in community care will affect the Trust's ability to deliver safe and effective integrated care pathways that ensure quality of care is uppermost and that admission avoidance and a reduction in re-admissions is achieved.

Lack of engagement of clinical staff
The Trust needs to ensure that clinical staff are engaged at every opportunity in service provision and quality improvement; this can be challenging in a fast-moving, acute hospital environment. There needs to be an investment in time and administrative support to ensure that clinicians are enabled to drive forward change and be at the forefront of this change; this will support local ownership and accountability and is more likely to ensure success.

Risk of not being able to modernise and reconfigure our hospital and facilities to enhance clinical quality and the patient experience:
Our estate needs robust maintenance and modernisation to ensure it delivers an appropriate care environment for patients and their families and carers moving forward. We need to ensure that we use capital resources to best effect and that clinical staff and patients are at the forefront of environmental improvement.

3.2.9 Financial Contingency

The Financial Plan assumes in total £1.5m (0.75%) of contingency. Indicatively, £0.5m has been identified as a contingency for commissioner challenges and contract penalties; £1.0m as a general expenditure contingency.

3.3 Operational Requirements & Capacity

The North West London Shaping a Healthier Future (SaHF) Programme, outcomes of the Mid Staffs and Keogh review and the move towards Seven Day Working are the key drivers influencing the Trust's operational and capacity plan for the next two years.

3.3.1 Shaping a Healthier Future – Operational Requirements and Capacity

The SaHF model indicates that in the longer term (2 – 5 years) there will be a significant shift of activity from acute hospitals into the community. This will be achieved by a greater focus on preventative health interventions, developing services in the community and re-classifying hospitals into two categories "Major" or "Local".

Hillingdon will remain a major hospital with an A&E department and expanded obstetric unit. Neighbouring Ealing Trust will be reclassified as a local hospital and will have its A&E department changed into an urgent care centre. In addition, the hospital will no longer provide obstetric services. As a result, a proportion of work will flow from Ealing to Hillingdon.

The outcome of the SaHF strategy will be that all hospitals will require fewer rehabilitation / recuperation beds. Major Hospitals will be expected to forge links with community services to ensure that patients only remain in hospital for the acute phase of their care. These hospitals will be expected to expand or contract services accordingly to accommodate shifts in activity from local trusts.

To support this strategy, Hillingdon has developed an operational plan to expand capacity in obstetrics, theatres, intensive-care, emergency and acute services.

Expansion of Acute Care

The current Acute Medical Unit (AMU) has 28 beds and can treat patients for the first 24 hours of their acute episode. If patients still require acute care after this period they are transferred to a speciality ward. Modelling suggests that a number of patients would have a shorter length of stay if they were able to remain on the AMU for longer periods, where a broader multi-disciplinary team could be located including community support services.

The new unit, which will be co-located with the Trust's A&E department, will open in January 2015. This co-location will facilitate better integration between hospital emergency and acute services and create an Emergency Care Department. This co-location also means that Rapid Response and the new Home Safe Community Team can be based in the same area and be able to provide seamless care pathways.

The new AMU will contain 46 beds and will be able to accommodate patients for up to 48 hours. Patients on the unit will remain under the care of acute physicians with in-reach from speciality teams. There will be a focus on intensive interventions to ensure patients are able to return home as quickly as possible.

A multidisciplinary clinical working group has been created to focus on developing the new models of care. The group is working with health care partners to maximise the potential of the new unit.

Expansion of Emergency Ambulatory Care

The Trust has a developed an Emergency Ambulatory Care unit (AEC). Further expansion of this unit is constrained by its physical environment. The unit is currently located four floors above A&E and does not have immediate access to rapid response or other community services.

The new EAC unit will be transferred to the new building co-located with A&E and will become part of the Emergency Department. The EAC has significant potential to expand services and help prevent avoidable admissions. The unit will accept direct referrals from GP's and from the Urgent Care Centre which is also collocated to A&E. This model is well developed in medicine and the new building will allow for a significant expansion of this type of care to be extended into surgery and gynaecology.

Expansion of Obstetrics

In May 2014 the Trust will relocate much of its inpatient gynaecology service (currently located next to the obstetric unit) to the Mount Vernon Site. The Mount Vernon site has sufficient theatre and bed capacity to absorb this service. The capacity created by this move will be refurbished to provide an extended obstetric unit capable of absorbing the initial transfer of Ealing activity (anticipated to be a further 800 births per annum). It is anticipated that the transfer of obstetric work from Ealing may happen as early as December 2014. Therefore it is necessary to transfer gynaecology in May 2014 to ensure the refurbishment is complete on time. This refurbishment will complement the work already undertaken to upgrade the Trusts existing labour suite.

As part of the SaHF Programme the Trust plans to complete an Outline Business Case for formal approval in May 2014 to expand the maternity and neonatal unit to accommodate up to 6,000 births (circa 2,000 more than is currently provided).

Expansion of Supporting Clinical Services

The SaHF modelling undertaken has identified that the hospital's theatres and ITU capacity will need to be expanded to accommodate the shift of activity from Ealing.

The Trust has submitted a business case to increase the number of ITU beds by 4, and create 2 additional HDU beds in maternity and 2 in paediatrics. The Trust will retain its 6 CCU beds and will have a total complement of 25 level 2/3 beds.

As part of this business case the Trust has also requested funds to expand the theatre suite by increasing the number of recovery bays. This will support enhanced flows through theatres by reducing bottlenecks and improving utilisation. This ultimately means that the Trust can meet predicted demand without building an additional theatre.

This modelling has also identified that the existing A&E department is not large enough to meet current demands. The Trust's A&E department needs to be expanded and re-configured to support the changing status of emergency medicine at Ealing hospital. The Trust has therefore also submitted a business to create a larger ambulance handover area and increase the number of major cubicles.

Workforce Impact

It is anticipated that the expansion of the Acute Medical Unit and Emergency Ambulatory Care will have a positive impact on patient length of stay. Based on our modelling it is proposed that there will be a net reduction of 30 general acute beds by the middle of 2015.

To deliver this strategy the Trust will need to increase the number of acute consultants and has approved funding for an additional acute physician in its 2015/16 budget.

The Trust will also make further investments and increase the number of emergency care consultants.

It is anticipated that the compliment of nursing staff required to delivery this strategy will remain static. However the skill mix will need to be reviewed and changed. This work will be undertaken in conjunction with the needs of delivering Safer Staffing Levels and Seven Day working.

3.3.2 Safer Staffing – Operational Requirements and Capacity

Under safer staffing programme the Trust intends to make a considerable investment to improve nurse to patient ratios on a number of wards. It is expected that savings in lengths of stay and reduction in bed numbers will also support further increase in nurse to patient ratios.

3.3.3 Seven Day Working – Operational Requirements and Capacity

Using winter funds made available in December 2013 the Trust funded a number of projects to expand a number of services over the weekend. These included expansion of therapy and radiology services, enhanced medial and pharmacy cover and additional managerial support. The success of these projects will be evaluated and will inform the Trust seven day working strategy, which will be developed by July 2014. It is anticipated that there will be significant workforce implications as the Trust looks provide a more uniform service model across the 7 days of the week.

3.3.4 Mount Vernon – Operational Requirements and Capacity

A key part of our strategy is to maximise the benefits gained from our Mount Vernon site, and the Trust is developing a marketing and capacity plan for the site. We are also in discussion with East and North Herts on potential options to restructure the Mount Vernon site arrangements.

This site currently houses a state of the art treatment centre, endoscopy, inpatient rehab wards and outpatient facilities with supporting diagnostics. The strategy supports the transfer of elective activity from the Hillingdon site to improve theatre utilisation and bed occupancy in the Treatment Centre. As previously stated, gynaecology will be relocated in May 2014. It is anticipated that there will be an increase in orthopaedic and other surgical specialties over the year as the Trust grows and diversifies its elective referral sources.

Following the repatriation of all non-elective acute activity to the Hillingdon site, Mount Vernon now has capacity to develop new services in the vacated space. A number of options are being explored and the first service development will occur in August 2014 with the opening of a new Neuro Rehabilitation Unit. The unit will have 16 beds and will be managed as an extension of the existing service operating on the Hillingdon Hospital.

3.4 Productivity, Efficiency & CIPs

This year the Trust has endeavoured to develop and drive a longer term transformation programme which has greater engagement and leadership of clinical teams. The Trust appreciates that tactical opportunities are now limited and in the coming years the focus needs to be very much on internal transformation programmes with a growing emphasis on health economy opportunities specifically around integrated care. The 14/15 programme is a £9m programme made up of both single year schemes and larger transformational schemes which are planned to deliver over 2-3 years.

The Trust has focused on developing Transformation schemes which continue to provide high quality for patients at lower costs. Last year about 50% of the programme was focused on large internal transformation programmes which focused on ensuring internal processes, pathways and systems work as efficiently as possible, this will continue into next year to further increase productivity. The internal transformation programme is complemented by longer term schemes which focus on health economy wide savings.

The 14/15 QIPP programme is made up of 35% division specific schemes (many of which are less tactical and involve changing the delivery model for patients in order to streamline the patient pathway and reduce costs, these are mainly focused around individual specialties), 55% large internal transformation schemes which focus on Trust-wide system issues or inefficiencies, 10% which focus on reducing cost through working closely with community partners. Over the coming 2-3 years greater savings through health economy wide schemes have been planned.

Integrated Care

Many patients have complex care needs and are regularly faced with health and social care services that are fragmented, resulting in patients and carers finding it at times difficult to access the right health and social care services to best meet their needs. Services are often provided by different professionals, in a number of settings, and across different providers without any help to navigate which at times resulting in poorer outcomes, with duplication and inefficiencies.

Health and Social Care commissioners and providers as well as the third sector are currently working together on future integration models of care in Hillingdon. The integration agenda has gathered momentum as a consequence of several drivers; these include the Better Care fund, Whole Systems Integration Pioneer plans, and North West London Integrated Care pilots. Hillingdon Hospital is also participating in the NWL early adopters programme for seven day services which is viewed as a key enabler for integrated care

In addition to the key drivers, the Trust is also paving the way for future requirements to provide care closer to home and again at a more frontline level help with the integration agenda. This is well illustrated by the implementation of an early supported discharge model of care that includes working very closely with Age UK, Community Health services and Social Care. Within this model we are working towards trusted assessments and also rotating staff to work in both acute and community environments.

The Trust's Transformational priorities are focused around 6 main themes:

- 7 day working
- Ambulatory Care
- Integrated Care
- Elective Pathway Redesign
- Operational Excellence
- Accessible and Responsive Services

All QIPP projects are aligned to these Transformation priorities; there are 7 Trust-wide Transformation Projects which aim to drive quality improvement and increase productivity and efficiency through Trust-wide enablers, these include:

- Improving Inpatient Care – focuses on improving the patient pathway in order to reduce length of stay (LoS). This programme of work includes further roll-out of the 13/14 Ambulatory Care project and Early Supported Discharge model. The project also continues the work from last year to improve ward processes to ensure timely discharge 7 days of the week through roll-out of criteria led discharge and review of resource changes which can make a significant return of investment in terms of reducing LoS and therefore the bed base. As part of the 13/14 programme, a ward was closed which will continue to remain closed this year, the plan is for a second ward to close in July, resulting in a total reduction in the bed base of 49 beds.

- Internal Referral Management – focuses on reducing inappropriate demand and understanding the demand drivers for Radiology and Pathology services. Pathway focused working groups have been set up to outline the appropriate pathway and the scans/tests within this to reduce inappropriate demand, duplication or waste due to DNAs.

- Maximising the utilisation of the Mount Vernon site – focuses on understanding the productivity differences across the 2 sites and identifying ways in which to increase the utilisation and productivity of the site. This scheme considers both redesign of service provision across the two sites, potential to repatriate activity and commercial opportunities for utilisation of the site.
- Accessible and responsive services – focuses on understanding and addressing all challenges to access that are experienced by the patients and GPs. The scheme consists of a 10 sub-workstreams grouped into 4 areas; a) Welcome – ensuring there is a single point of access for patients, improving the patient journey within the Trust and consolidating reception areas, b) Booking – improving the processes around Choose and Book and further centralisation of bookings, c) Administration – reviewing the provision of admin support and structures and introducing IT solutions to increase quality and reliability, d) Outpatient service models – implementing the most effective outpatient models in order to improve the patient journey.

Other Trust-wide schemes include; building a sustainable and safer nursing workforce, reducing the use of temporary staffing, procurement and Integrated Care.

All of the larger transformational schemes have detailed plans to support them which have been developed in collaboration with the core delivery teams which includes clinicians, managers and project support. All schemes are in the process of developing Quality Impact Assessments which will be reviewed via the Trusts Clinical Assurance Panel.

QIPP Profile

The total for the schemes identified is £9.0m in 14/15 and a further £9.0m in 15/16 and 16/17. The schemes identified for year 1 are at a more granular level of detail than those identified for year 2 and 3. These schemes are all recurrent and are expected to continue delivering for the subsequent periods. £1m of the 14/15 value is attributed to schemes which started to deliver in 13/14 a further £3.5m is related to some of the larger transformational schemes from last year where a significant amount of work-up has occurred in 13/14 to enable delivery in 14/15. Delivery of QIPP in both 14/15 and 15/16 has been risk adjusted within the Financial Plan, reducing planned QIPP delivery to £7.5m in both years.

QIPP Governance

The Trust's Transformation and QIPP programme is supported by the Project Management Office. In 13/14 robust governance processes were put in place which have been reviewed and further improved for 14/15. Some of the 13/14 lessons learnt included; starting the planning process earlier than in previous years; increasing the amount of clinical engagement and leadership; further improvements to the planning detail for each scheme; and improved performance KPI tracking against each specific scheme. The planning process for 14/15 began in October and a large Transformation event was held in November with a significant proportion of clinical attendees. This has been followed by a number of smaller workshops including many with clinical teams to work up their ideas.

There are clearly articulated processes for the development of schemes, the processes ensure that schemes are financially viable and do not negatively impact quality. All projects are developed and delivered within a framework. The PMO risk rates schemes within a weekly and monthly cycle to flag risks to delivery and also to support project leads to put in place mitigating action to avoid slippage.

In order to ensure that there is no negative impact on quality all schemes go through a robust Quality Impact Assessment process. During the initial development of the Project Initiation Document any risks to quality are flagged and assessed, dependent on the initial risk assessment a full QIA is then populated and submitted for review at the Clinical Assurance Panel.

The process for clinical review of schemes is outlined below at a high level.

- Scheme is scoped by divisional teams – Project Initiation Document completed with a high level quality assessment.
- Impact on risk is considered by the divisional clinical teams - Quality Impact Assessment is populated as part of this process
- Initial sign-off by the division
- Scheme is then submitted to the CAP for review and scrutiny by the panel
- Outcomes agreed:
  a) signed off
  b) signed off subject to the development of a quality KPIs dashboard and clear regular monitoring process by the project team
  c) not signed off with a request for further information
  d) not signed off

3.5 Financial Plan

i. *Income, and the extent of its alignment with commissioner intentions/plans;*

Agreed activity and related revenue plans are fully aligned with commissioners. The Trust has worked collaboratively with its host commissioner over the last year to align short and long-term commissioning intentions with its own strategic financial plans. Crucially, this includes agreement with the North West London strategic commissioning plan for acute provider reconfiguration where the Trust has an agreed end-point status as a major acute.

The Trust has an agreement in principle for its 2014/15 healthcare commissioning contract with North West London CCG's. It also has agreed financial envelopes with all other major contracts, including associate commissioners and NHS England. These agreements reflect in excess of 97% of the Trust's contracted commissioning revenue for 204/15.

The most significant contract with the Trust's host commissioner, Hillingdon CCG, has been constructed following a very similar structure to the one successfully implemented in 2013/14. The commissioner intends to deliver activity to a maximum value of £110m as charged under PbR, but the Trust will receive transitional funding to guarantee a minimum sum of £114.9m. This will require Hillingdon CCG to deliver £5.7m of QIPP schemes during 2014/15. All the other contracts are full PbR cost and volume. The values stated are all pre-CQUIN, which will be paid on the actual value of activity provided to a maximum uplift of 2.5%.

The key service development planned during 2014/15 is the opening of a further specialist rehabilitation facility on the Mount Vernon Hospital site. This is expected to generate an additional £1.5m income from out of area commissioners and generate a contribution of £0.4m. No further service developments have been built into the Annual Plan at this stage for 2015/16.

Commissioning income for 2015/16 assumes the full delivery of a further £9.5m of commissioner QIPP schemes to move activity out of hospital together with £12m of transitional fixed cost support funding.

Non-commissioning income is based on 2013/14 forecast outturn adjusted for inflation, with the exception of Training & Education that increases by £0.3m following the introduction of tariff funding for postgraduate medical education and the reduction in the transitional adjustment for undergraduate medical education.

ii. *Costs;*

The key expenditure movements during 2014/15 are inflation pressures (£4.3m), delivery of provider QIPP schemes (-£7.5m), investment in quality standards (£2.2m), cost reduction

following commissioner out of hospital QIPP schemes (-£1.5m) and expenditure contingency (£1.0m).

With the exception of increased inflation pressures to reflect expected changes to employer's N.I. and superannuation contributions (£5.6m) and increased cost reduction following a further tranche of commissioner out of hospital QIPP schemes (-£4.3m), all other expenditure assumptions are repeated in 2015/16. The increased cost reduction following Commissioner QIPP schemes is caused by both a higher level of QIPP delivery assumed in 2015/16 and also by the Trust anticipating the release of higher associated semi-fixed costs over time.

£1.1m of additional expenditure associated with the opening of an additional Specialist Rehabilitation ward has been incorporated into the plan for 2014/15.

Tariff deflation of -1.5% 2014/15 and -0.95% 2015/16 has been assumed within the financial plan. In both years expenditure inflation assumptions are consistent with the inflationary funding implicit within the tariff deflator assuming a national requirement to deliver a 4% per annum efficiency improvement.

Quality Investment has been set at £2.2m for both 2014/15 and 2015/16 as a key part of the Trust's commitment to fully deliver the London Healthcare Provider Standards in a phased approach by 2017/18. Investment for 2014/15 has concentrated on staffing levels for maternity, consultant availability, ward nursing staff levels and early supported discharge.

iii. *Capital Plans*

An estimated impairment of £8.1m has been included in the plan for 2014/15 following completion of capital schemes for Emergency Care, Dementia and Maternity all funded by Public Dividend Capital from DH.

In addition to £5.2m cash required to complete the Emergency Care scheme the Trust plans to spend a further £7.5m on capital during 2014/15 and £7.0m during 2015/16. Capital expenditure above depreciation on Trust assets in 2014/15 has been funded using the cash surplus generated in 2013/14.

The 2014/15 capital plan has broadly been allocated as £3.9m to Estates, £1.3m to Medical Equipment, £1.5m to Information and Technology and £0.8m to contingency. Priorities have been risk assessed and approved by the Trust Board.

iv. *Liquidity*

Primarily due to planned slippage with the Emergency Care capital scheme the Trust's liquidity ended better than plan in 2013/14. During the 2014/15 financial year this will unwind completely. The impact of this will be to reduce the Trust's forecast liquidity, as measured in the Continuity of Services Risk Rating, from -0.4 days at the end of 2013/14 to -10.0 days at the end of 2014/15.

v. *Risk ratings.*

Despite the planned reduction in liquidity during 2014/15 the Trust is forecasting to maintain a Continuity of Services Risk Rating of 3 for both 2014/15 and 2015/16, with individual ratings of 3 for Capital Service Cover and 2 for Liquidity.

Downside risks and mitigations

The Trust has assessed the most likely downside risks to the Trust achieving its 2014/15 and 2015/16 financial plans. Risks with a total value of £5.6m have been identified that

would impact on revenue or operating expenses. Their most likely impact has been assessed at £4.2m and can be fully mitigated with a range of agreed measures.

A worst case has also been assessed taking into account the full identified value of the risks together with a more pessimistic view that only £4.0m can be mitigated. If this scenario occurred the Trust's continuity of services risk rating would drop to a 2 whilst more substantial further measures were considered by the Board to restore financial balance and a rating of 3.

The assessment of financial risk has taken into account the impact of the contract agreement in principle with Hillingdon CCG. This continues to offer financial shelter against the downside impact of the commissioners out of hospital strategy.