

Operational Plan Document for 2014-16

University College London Hospitals NHS Foundation Trust

1.1 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	04/04/2014

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 (Chair)	Richard Murley
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Sir Robert Naylor
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Richard Alexander
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Signature



1.2 Executive Summary

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, with over 50% of activity now commissioned by NHSE as part of specialist services contracts. Our turnover is £885 million we contract with over 90 commissioning bodies. We see over 950,000 outpatients, over 125,000 A&E attendances and admit over 156,000 patients each year.

The projected continuation of wider economic pressure will persist in placing financial pressure on the UK health and social care system. As such further pressures on health spending are anticipated as a result of the 2015/16 spending review, with the NHS budget likely to be flat-lined for an estimated further five years. The proposed shift of £3.8 billion of funds nationally from health to social care will place additional pressure on the NHS unless this explicitly results in early demand reduction. To address some of these financial and operational pressures we will be scaling up our Lean transformation to fundamentally redesign and improve our services. This programme has been incorporated within the top ten objectives for the coming year.

In 2013 London Cancer produced a 'Case for Change in Specialist Cancer and Cardiac Services'. Proposals are being considered by commissioners based on a plan to centralise specialist cancer treatment at UCLH across NE and NC London. The proposal also includes the transfer of cardiovascular services to Barts Health across a similar health economy creating an integrated cardiovascular system while thoracic surgery will be retained and moved to the main UCH site with a plan for growth and expansion as part of the overall desire to improve the outcomes of patients with lung cancer.

Networked and collaborative working to further develop the integration agenda will increasingly become the way that we must work in order to provide the best, personalised and most appropriate care for patients whilst at the same time supporting our referring partners in primary and secondary care.

2014/16 will be a period of substantial change for the Trust; however we believe we are in a strong position to meet these challenges.

1.3 Operational Plan

THE SHORT TERM CHALLENGE

The health economy and our commissioners

The shape of healthcare provision required and expected by the UK population is changing. This shift is influenced by the global economic climate, development of technology, medical and scientific advancements, and a series of high profile reviews of NHS services as well as population health trends.

As with all societies with an ageing population, the UK has an increasing need to provide care for individuals who are often socially isolated and who have complex, long term health needs. We believe this will require a radical transformation of traditional models of health and social care.

The rapid development of new technology, including social media, has enabled patients and the public to access more information about the availability of novel treatments and interventions, as well as the performance of individual clinicians and healthcare providers. Alongside the high profile reviews published by Francis, Keogh and Berwick, this ready access to a breadth of information has served to increase the expectations of the UK population in relation to health and social care services.

There is increasing difficulty nationally in staffing a number of key areas of clinical service delivery. Good examples of this include the Emergency Department and the provision of experienced middle grade doctors and consultants; the same is true of Obstetric units and the provision of appropriate consultants. In addition, there will be a reduction in the number of nursing trainees in 2015/16.

The projected continuation of wider economic pressure will persist in placing financial pressure on the UK health and social care system. Further pressures on health spending are anticipated as a result of the 2015/16 spending review, with the NHS budget likely to be flat-lined for an estimated further five years. The proposed shift of £3.8 billion of funds nationally from health to social care will place additional pressure on the NHS unless this explicitly results in with early demand reduction.

Commissioners are responding to these challenges by reshaping traditional financial flows and models of care. Local Clinical Commissioning Groups (CCGs) are increasingly working with local authorities to construct more sophisticated payment mechanisms that will deliver fundamental changes in care delivery.

We have been part of the discussions with CCGs and local authorities on the most effective ways of using policy levers such as the Better Care Fund to drive more efficient and effective care in the health sector. It would however be of even more impact if we could be a formal part of the Health and Wellbeing boards locally. We are very supportive of the general thrust of the Better Care Fund policy and are very keen to be at the heart of the planning, decision-making and implementation of the policy in our local health economy. We are clear that this continued involvement with our local CCGs will support the best outcomes for patients and also help us manage the inevitable impact of the policy on our business.

We have however asked our host CCG to clarify how we can be fully engaged in the detailed planning and implementation of the policy, including being part of the steering group for the BCF in Camden. We have also asked for our CCGs' assessment of the impact of the BCF on our activity levels, and will work this through as part of detailed negotiations for 2014/16. We are particularly keen to know how specific BCF schemes are intended to drive reductions in acute activity. This is the area where we feel we can work with CCGs/local authorities to come up with robust and achievable plans. These discussions will be part of our broader agreement on activity baselines ready for 2014/16.

Specialist commissioners have expressed intent to reduce the number of contracts issued for specialist services, moving towards a lead provider model. The need for critical mass in ensuring clinical expertise in specialist services has been acknowledged and it is likely that in future commissioners will seek further centralisation of specialist services. We believe that in many areas this will support a flow of additional work and resources to our tertiary teams. There are also some areas where specialised commissioners are proposing that activity will move from UCLH on account of the assessment against service specifications. Discussion of these issues currently forms a substantive part of our negotiations with NHS

England on the 2014/15 contract.

The NHS provider landscape is changing rapidly. The foundation trust approval process is likely to trigger further opportunities for partnerships, chains and greater alignment between provider organisations. Gradual shifts to integrated care models and the increasing concentration of specialised services will also have a significant impact on the composition and objectives of providers across London.

Networked and collaborative working will increasingly become the way that we must work in order to provide the best, personalised and most appropriate care for patients whilst at the same time supporting our referring partners in primary and secondary care. UCL Partners will continue to facilitate sector wide change and identify opportunities for collaboration between providers to improve patient care and also augment the research and implementation of change via the CLAHRC.

Clinical Services Strategy

Reconfiguration of cardiovascular and cancer services

In early 2013 London Cancer proposed to commissioners that UCLH be designated the centre for prostate and bladder surgery. There have been previous commissioner decisions to centralise most of the brain cancer and teenage cancer services at UCLH as part of a process to increase the volume of specialist activity in fewer centres and drive up experience and clinically improved outcomes. It has also been suggested that UCLH might be best suited to take a leadership role in the overall organisation of radiotherapy for the Sector for the same reason, although much of this service will continue to be provided locally.

In October 2013 London Cancer produced a 'Case for Change in Specialist Cancer and Cardiac Services'. This Cancer proposal is being considered by commissioners and is based on a plan to centralise still further specialist episodes of the cancer patients' journey at UCLH across NE and NC London. The particular areas of focus are bladder and prostate cancer, Upper GI, Head and Neck and Brain cancer (along with Queens in Romford). Haematological cancer will also be centralised at UCLH and Barts Health with important local high level service provision available where appropriate.

As part of the discussions around cancer reconfiguration a parallel set of discussions are taking place recommending to commissioners the centralisation of cardiovascular services to Barts Health across a similar health economy. With all cardiac services moving from the Heart Hospital and the London Chest the aim would be to create an integrated cardiovascular system while thoracic surgery will be retained and moved to the main UCH site with a plan for growth and expansion as part of the overall desire to improve the outcomes of patients with lung cancer.

Both sets of proposed reconfigurations are currently under consideration by NHS England (London) and the local commissioners.

In November 2011 the Trust Board reviewed the organisation's service strategy and agreed to focus on development of three service areas with the potential to become world leading from 2012/13:

- Cancer Services
- Neurosciences
- Women's Health

In order to deliver world leading excellence in these three specialties it is essential to develop a strong base in core medical and surgical specialties. Any strategic intent to grow the priority specialist services must be underpinned by appropriate investment in core medical and surgical services and in the delivery of high quality local care to the population we serve.

Cancer services;

We have identified cancer as a service where we want to be a European leader. In the short term our priorities include reaping the benefits of the innovative service models in our new Cancer Centre, delivering a step change in patient experience (in partnership with Macmillan Cancer Support) and

implementing the Proton Beam Therapy strategic development.

We support the UCL Partners strategy to reconfigure cardiovascular and cancer services across North Central and North East London, concentrating specialist activity in fewer better equipped centres, seeing more patients with the aim to improve patient outcomes and the overall quality of care. We want the whole population to benefit from the national and international excellence in diagnosis, treatment, and care that we deliver here at the UCLH. Our work on cancer emphasises partnership working so that patients are seen locally wherever this is possible.

The key short term strategic objectives will be;

- Support delivery of the proposed reconfiguration of specialist cancer services in North East and North Central London
- Deliver appropriate business cases to ensure the Proton Beam Therapy and Phase 4 above ground facility are delivered in 2018
- Improve the experience of cancer patients and their families across the health system, in partnership with Macmillan Cancer support
- Improve outcomes through world leading translational research, in partnership with UCL and Cancer Research UK

Neurosciences;

We already have a world-class neurosciences service. There has been a dramatic expansion of clinical services and research activity in the last five years, with growth in activity close to 80%. Neurological diseases such as stroke, dementia, Parkinson's disease, multiple sclerosis, neuromuscular diseases, epilepsy and brain tumours represent an enormous and growing health burden on society. By 2020 one million people in the UK will have dementia, costing 1% of GDP (World Alzheimer Report 2013). It has never been more important for combined clinical and research centres to develop the critical mass of expertise and facilities to advance translational research in order to develop and deliver effective therapies for more patients.

There are major new opportunities to deliver high quality integrated neurological services across UCL Partners, including better links with DGHs as part of a "hub and spoke" model and providing general and urgent services to our local population, integrated with community services. More broadly we will continue to recruit super-specialised staff and facilities for quaternary services.

We must ensure that academic and clinical priorities are aligned where possible, build on the successful Wolfson bid to develop experimental neurology and increase recruitment to clinical trials.

The key short term strategic objectives will be;

- Unify clinical services which are currently duplicated across the trust and local health system
- Develop new models for assessing and treating chronic neurological conditions
- Enable the delivery of the 20 year clinical strategy by developing appropriate business cases to support service expansion
- In partnership with UCL, maintain Queen Square's position as the leading national European centre for neurosciences

It is clear however that growth in demand for our neurosciences service will consume all existing spare bed and theatre capacity. Neurosciences will be one of our capital and estates priorities for the next ten years.

Women's health;

UCLH is currently a major provider of maternity services to the local population delivering almost 5,500 births per annum. It also plays a key role in supporting complex maternity services for populations much further afield than Camden and Islington. The neonatal care service is a recognised centre of excellence and supports acutely ill and pre-term babies from across North and Central London and beyond as does our leading foetal medicine service in which we see patients from across the wider population.

Alongside this UCLH has a national and international reputation for gynaecological service provision especially in the field of gynaecological cancer. The Trust also provides breast cancer care to just under 200 newly diagnosed women per year and plays a key role in supporting the local population with more general breast care support.

The key short term strategic objectives will be;

- Expand the existing infrastructure to support 7000 births per annum, with appropriate medical and midwifery presence to ensure world leading care
- Grow UCLH's national and international reputation in the field of gynaecological cancer service and translational research delivery
- Develop UCLH's role as the network lead for neonatology and complex maternity service provision and continue to deliver world leading outcomes in neonatal care
- In partnership with London Cancer, ensure the most appropriate sector configuration for breast cancer surgery and local diagnostic provision

Medicine

Responding to the increasing pressures on our urgent care and local health provision we will continue our emergency department development to sustainably meet the needs of our patients, but also national access target. We will further develop our ambulatory emergency care and clinical decision unit models to mitigate emergency admissions and augment our ability to provide ambulatory care to a wider proportion of all medical patients.

Critical care, whilst reaching capacity internally will play a critical role in the plans for our site development as well as, we hope a sector wide role as the exemplar intensive care unit in the area.

Medical specialities are working closely with our integration division building models of care enabling more patients to be treated out of hospital and closer to home for patients and carers. We have grown our Care of the Elderly capacity to meet the increasing demand in this area, but also work closely with our communities to better manage those complex patients in this group and thus avoid deteriorations and admission. We will also be appointing our first professor of healthy aging, as exciting development with UCL.

In pathology we will go live with our Joint venture with Royal Free and The Doctors laboratory, finally taking forward the vision of The Carter Report. In wider clinical support, in addition to supporting moves to 7/7 working we will build on our business development ideas to maximise efficiencies and quality of service as well as other potential opportunities.

Better Care Fund (BCF)

In 2015/16 a pooled health and social care fund called the "Better Care Fund" (BCF) (previously known as the Integrated Transformation Fund) will be established. The BCF is intended to drive health and social care services to work more closely together in local areas, delivering better services to older and disabled people, keeping them out of hospital and avoiding long hospital stays.

The current Camden CCG/local authority draft plan contains the following broad workstreams:

- Investment in community support services, reducing demand for residential based care
- Telecare and telehealth
- Re-ablement services
- Support for people with mental health problems
- Supporting hospital discharges
- Admissions avoidance schemes
- Use of better case management, including personalised care plans and personal budgets

As well as needing to deliver demonstrable change against key performance metrics the plans must meet, among others, the following conditions:

- Seven day working in social care
- Better data sharing between health and social care based on the NHS Number
- Agreement on impact of changes on the acute sector

Whilst there is specific work supporting the introduction of the Better Care Fund, we are actively working with our commissioners on a broader agenda to support the integration agenda. The main areas of focus will initially be on long term conditions, lifestyle issues and vulnerable patients. The intention of the key CCGs will be to pursue value-based commissioning introducing outcome measurements. The main areas for 2014/15 will be diabetes, frail older people and severe mental health problems.

There will be a number of themes that will facilitate both improvements to services and the introduction of common efficiencies across the health economy. These will include developing tariff structures that share risks through the system. Shared efficiency schemes could include reducing hospital bases out-patient attendances, reduction in the level of excess bed days and the provision of mental health services.

QUALITY PLANS

We are developing a good track record on the quality of the services that we provide to our patients:

- Some of the best mortality figures in the country
- Positive CQC inspection reports
- Positive feedback from our patients through surveys

But we have areas where we can see room for improvement. In the wake of the mid Staffordshire report Francis, Keogh and Berwick have thrown down a number of challenges to all trusts. We have taken a number of key messages from these reports. We have undertaken a gap analysis against the Francis recommendations and found no areas of significant weakness. We have a Board sub group (including executive and non-executive directors and governors) overseeing progress against the actions we have identified we can take to improve our processes and culture. We are also integrating improvement work from the Berwick and Keogh reports into this group. These issues have been discussed by our Board of Directors as part of its seminar series and they have been reported to our Governing Body.

Perhaps the most striking point has been the imperative of listening to and learning from patient feedback. While we perform reasonably well on measures of patient experience, we feel that there is much more that we can do to understand what patients think about our services and to identify services which are below the standard we would expect at UCLH. We want all our staff to understand the importance of listening to patients and responding to their individual needs. And we need to pull out themes from patient feedback, from ward to organisational level, to know where to target our efforts to improve services. Complaints from patients are a particularly rich source of intelligence that we need to do more to learn from. To progress this issue it has been incorporated into the trusts top 10 objectives for 2014/15 to improve patient experience using all sources of feedback.

We also know that we can do more to ensure a consistency in care quality across weekends as well as during the week and out of office hours as well as during office hours. A key strategic theme in the medium term will be investing in staffing and new ways of working that will provide the same quality of care 24 hours in every one of 365 days of the year.

We have a few areas of immediate challenge in terms of quality metrics, although we do not see these as part of any fundamental strategic weaknesses:

- Infection: we have not been performing well against Clostridium difficile thresholds. While we feel that in part it is an issue of a poorly constructed performance measure, we will continue to improve our practice in some

key areas, in particular driving through further improvements in environmental cleanliness and antibiotic stewardship. This will be tracked by a fortnightly infection group led by Jonathan Fielden, medical director for Medicine Board.

- Pressure ulcers: while we are not worse than average on this measure, we have not seen the improvements that we wanted having identified this as a priority in 2012/13, and so it remains a key challenge for our nursing teams. Improvement work is led by our Chief Nurse Katherine Fenton.

The recent Care Quality Commission inspection identified a number of areas of improvement in our acute services. Specifically there were four areas where we were given compliance notices. For each of these we have a project plan for the improvement work, with weekly update reports to a programme board chaired by our CEO. While we anticipate that significant progress will be made on these by the end of Q4 2013/14, there will be longer term improvement work on each of these that goes into 2014/15:–

- Full compliance with the implementation of the WHO safe surgery checklist
- security of records
- improved nursing documentation
- improvements to the A&E environment.

There were also other areas that the CQC cited as requiring attention, and we will address these through the same project approach described above:

- Children's A&E provision
- ITU cleaning support and equipment storage
- surgical patient flow – beds and theatre recovery
- DNAR assessments and documentation

We liaise closely with our commissioners on quality issues through our Clinical Quality Review Group which meets monthly to discuss current performance against agreed standards and to work through a work-plan that we set together annually. The priorities that we identify above fit well to the CQRG agenda and the areas of interest for our commissioners.

In summary, our Quality Account and Top 10 objectives will focus on the following priorities:

1. Improve patient safety

- Reduce hospital acquired infections, pressure ulcers, falls and missed medications
- Develop plans to move to 24 hour / 7 day working where appropriate
- Improve how we share learning across the organisation from safety incidents and patient feedback.

2. Deliver excellent clinical outcomes

- Improve outcomes against Trust-wide and specialty-specific measures
- Reduce avoidable emergency admissions
- Achieve access standards and the right clinical staff across emergency pathways

3. Deliver high quality patient experience and customer service excellence

- Develop standards for patient experience (as customers)
- Develop the "Making a difference together" programme to improve patient feedback
- Make it easy for patients to give us timely feedback and act on it

Providing assurance on quality issues

We provide assurance to our board of directors on the quality of our services through the Quality and Safety Committee (QSC) and a number of groups that report to it.

The QSC receives a monthly quality performance pack, the key parts of which are also reported to the Board of Directors in the monthly Trust performance pack.

Quality issues are also comprehensively covered in our risk framework and board assurance framework reporting structures. These include regular reviews of quality risks on risk registers across the organisation. The assurance framework also covers strategic risks. There are also regular reports on incidents, complaints, safeguarding and clinical audit.

We carry out quality impact assessments for our savings projects and discuss these with our commissioners at Clinical Quality Review Group.

We also make extensive use of internal and external benchmarking (including with the Shelford Group trusts on a range of issues).

Our internal audit programme covers a range of key quality areas. The Quality Account audit programme also provides us with external assurance on our quality controls.

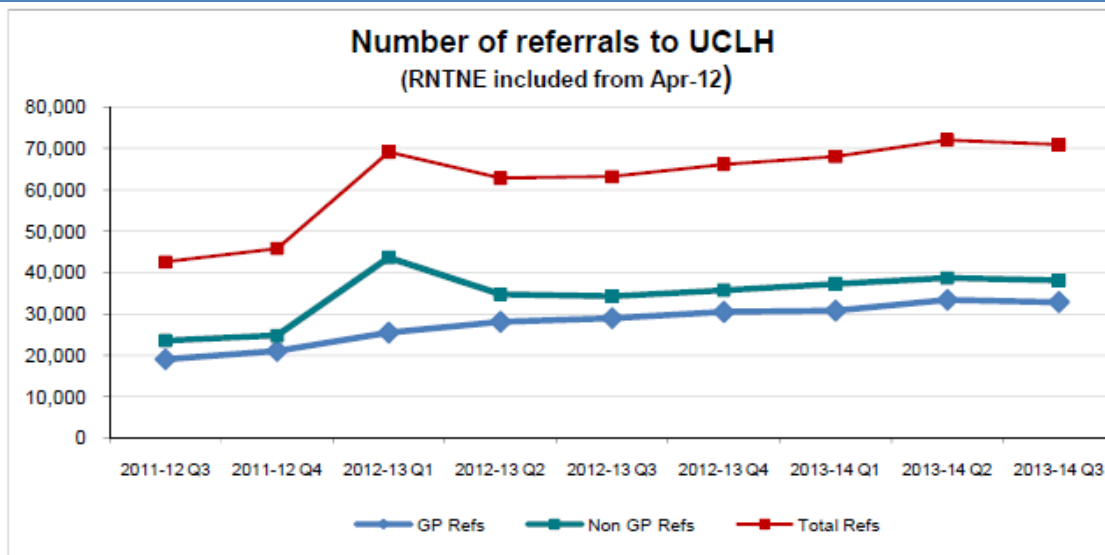
OPERATIONAL REQUIREMENTS AND CAPACITY

We believe that referrers send us more work because of the outcomes we deliver. Patients have a positive experience of care at our hospitals and choose to come to our hospitals. We have also become more responsive to what GPs want from us as a service, using GP relationship managers to discuss issues, strategic developments and manage concerns that primary care may have with the services we provide to them and their patients. In addition to this some increases are due to changes in healthcare provision across north London together with changes in the population demographics.

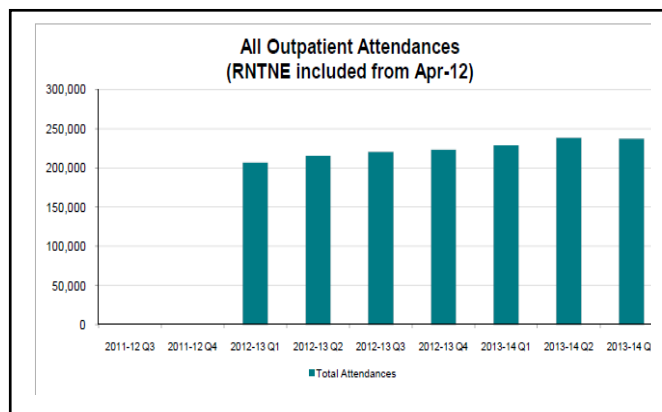
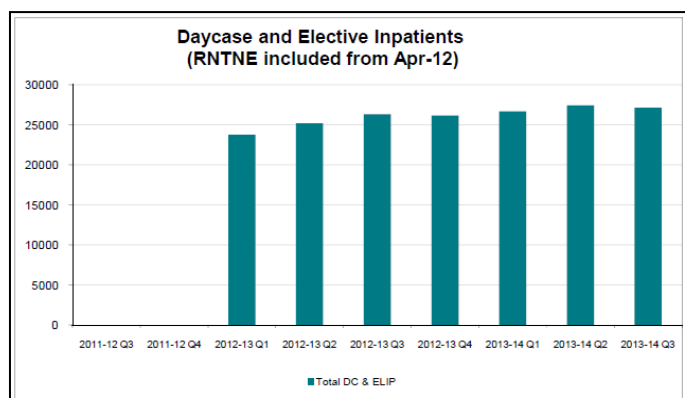
Demand has continued to rise for many of our specialist and tertiary services with notable increases for:

- Cancer: our introduction of new and innovative treatments is just one driver of improved outcomes. With the proposed changes in the reconfiguration of cancer services across London trusts and plans for proton beam treatment, we anticipate that we will continue to increase our cancer services activity over the coming years
- Neurosciences: movement of work from local and regional providers, partly through transfers of service but also through patient and referrer choice
- Maternity: 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

GPs and other clinicians continue to send an increasing number of patients to us for treatment as already shown. Since the RNTNE became part of UCLH we have seen a continual increase in referrals quarter on quarter.



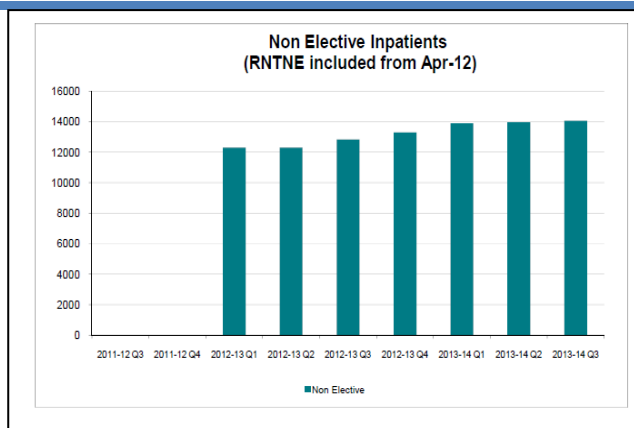
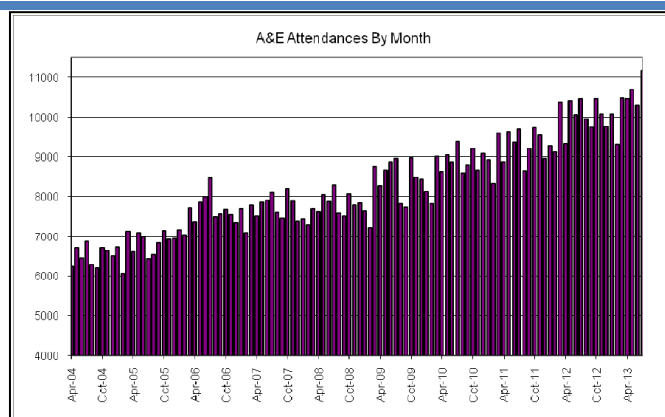
This increase in referrals has led to increases in elective and out-patient activity, in addition to an overall increase in the trust waiting list.



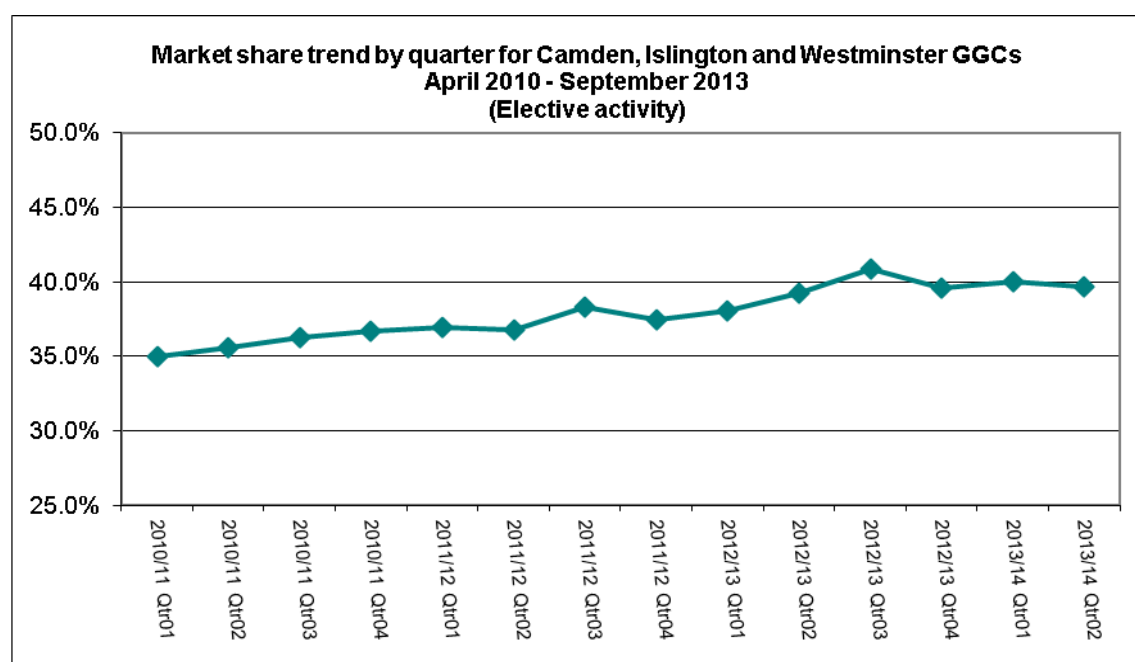
The growth in patients waiting since January 2013 has increased by 28%



In addition to the increases in elective activity, we have managed growth in emergency and non-elective cases.



The increases seen are not just due to the national growth in acute care. We have continued to grow our proportion of market share for our key CCG commissioners;



Activity plans 2014/15 and 2015/16

The table below shows the indicative changes in activity levels for 2014/15 and 2015/16 compared with the 2013/14 year end forecast. Growth across A&E attendances and admitted care continue.

We also forecast that increased activity levels for 2014/15 will be required in order to meet and maintain RTT waiting times with appropriate adjustments added to contract proposals to commissioners with the backlog clearance clearly identified as a non-recurrent adjustment

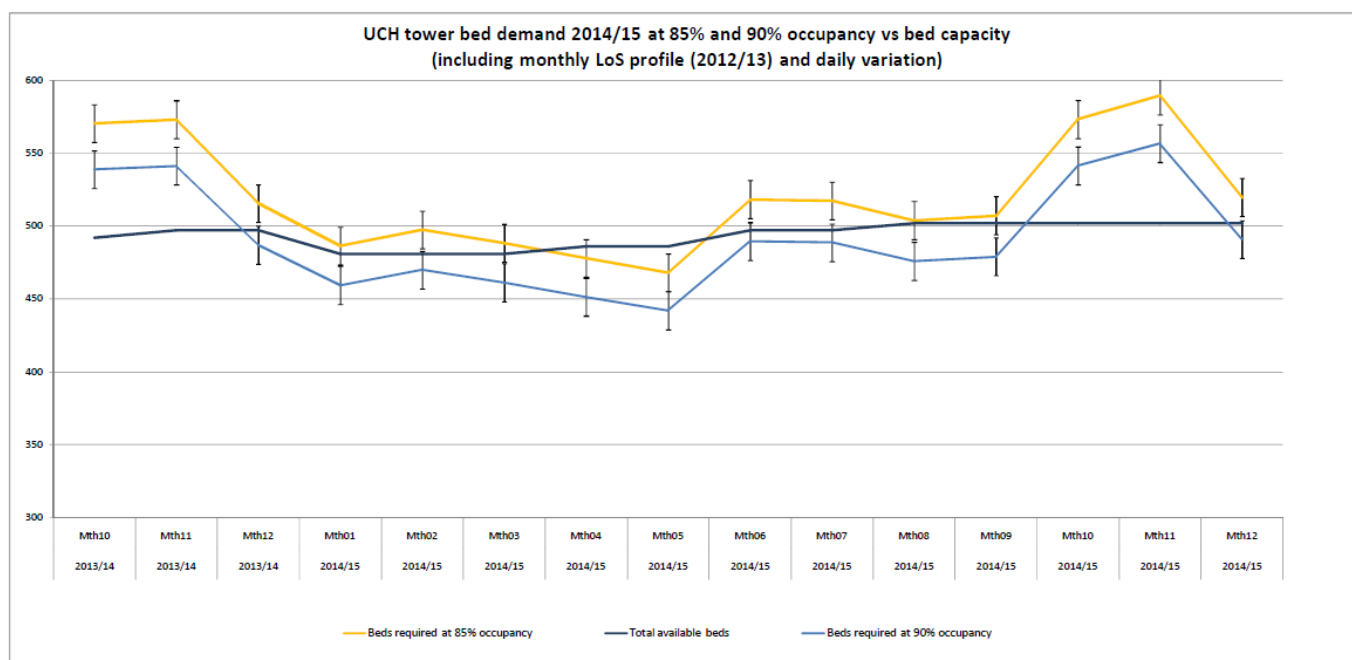
Activity	Outturn	Plan	
		2014/15	2015/16
Elective in-patients	24,143	26,336	24,657
Elective day cases	81,174	91,853	96,903
Non-elective in-patients	47,035	49,896	51,152
Out-patient first attendances	196,705	218,656	219,774
Out-patient follow-up attendances	605,896	640,681	664,309
Out-patient procedures	128,190	129,608	120,781
A&E	126,402	133,148	142,468
Other NHS Activity (Various)	270,514	281,321	279,090

Capacity Planning

This increase in admitted care will continue to place pressure on available bed capacity so projects continue to identify alternative ways of managing patient pathways,

The current activity plan which informs our internal bed modelling indicates that we will experience significant bed pressures within the UCH site during quarter 4 of 2014/15. We are progressing projects within the trust to increase bed capacity and to introduce a “hospital@home” project, improving discharge planning and increased admission avoidance schemes.

Whilst the position on the chart is at this point a concern, it should be noted that the indicative gap the model calculates is the same as in the final months of 2013/14 where we have, to date, been able to manage demand and to improve four hour wait performance for A&E attendances.



We are also experiencing pressure for operating theatres to accommodate the increases in activity. As part of the longer term strategic planning our new builds will include additional theatres. During the interim period we expect the introduction of planned weekend and evening working and targeted improvements in utilisation rates to provide the necessary theatre capacity for additional activity.

Implications for performance against key performance measures

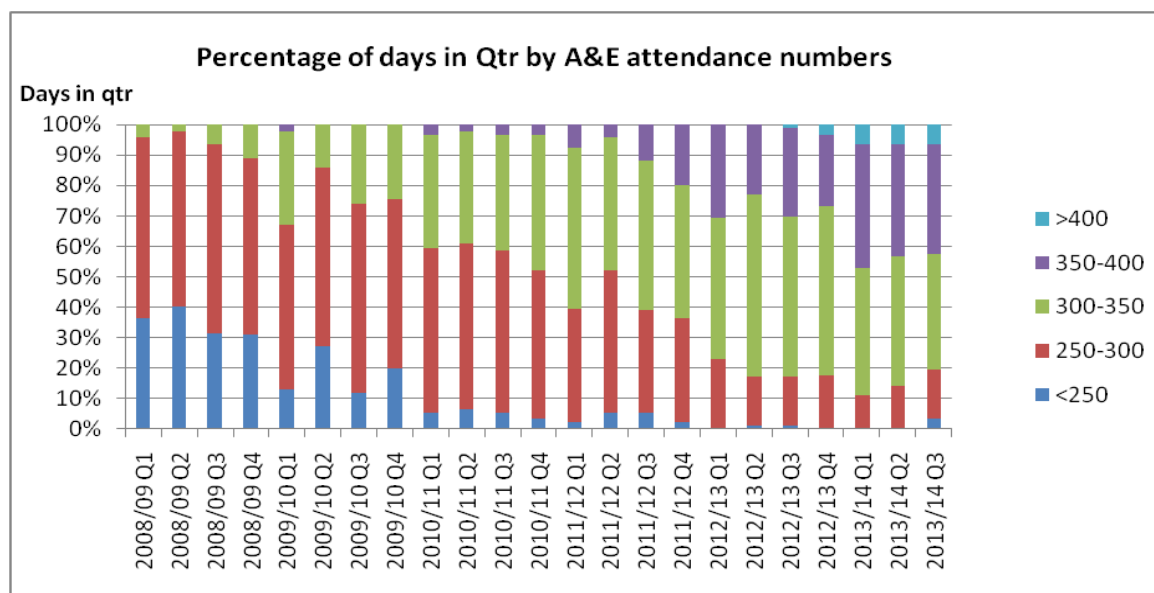
Limited capacity in the context of growing demand for elective and non-elective services generates significant risks in relation to targets for A&E waits and RTT waits.

A&E 4 hour wait

As reported to commissioners and Monitor we continue to see increasing numbers of attendees to our A&E department with high numbers of admissions.

To cope with increased attendances and to improve our performance we have made significant changes; we have invested in more A&E staff both medical and nursing in addition to improving the operational performance management. We have also introduced a much tighter process for improving patient flow through the UCH tower site which has resulted in fewer patients waiting for admission to beds.

We have also created a new clinical decision unit in addition to increasing physical space by taking over an area of the adjacent clinical research facility. In addition to these A&E improvements, additional beds have been introduced both on site and off and we are progressing plans for the introduction of the hospital@home project. The next stage of the A&E expansion project will continue with an expected completion date in 2015/16. This new emergency department will include a clinical decision unit, more majors cubicles a new mental health suite an integrated urgent treatment centre and a new paediatric area.



A&E attendances April 2008 – December 2013

Whilst the initial improvements are having a positive impact on performance close monitoring and review will remain to identify increasing risks and potential opportunities to completely mitigate them before the final developments are completed.

Referral to treatment

We have seen continual increases in referrals which has resulted in a gradual rise in the number of patients waiting (incomplete pathways) for treatment. As a result we have seen a growing number of patients waiting over 18 weeks with capacity growth now limited.

We consistently met RTT targets until late in 2013 where the increasing referral numbers impacted on the volume of patients with waits over 18 weeks. Monthly performance deteriorated slightly but due to data quality issues we were able to consistently achieve the targets by continual validation of reported

We have introduced a comprehensive action plan around the management of waiting lists which includes significant improvements to the data quality problems we have identified. This will ensure we are able to introduce effective modelling of future demand.

We have recruited McKinsey who are supporting us develop and recommend to the board, options for us to deliver a compliant position at both trust and specialty level in the short, medium and long term. In support of the implementation of the operational action plan we have also engaged MBI (consultancy) to review processes and culture within the trust to embed a sustainable improvement to the day to day management.

Productivity, Efficiency and Cost Improvement Programmes

QEP Process

The Trust's Quality, Efficiency and Productivity 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.

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 improve (and as a 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 bed occupancy. Again, this creates the right incentives for improving efficiency as each clinical board is charged the costs that they can influence or control.

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). Our Trust wide QEP template includes a Quality Impact Assessment (QIA) for each scheme. This is completed by Divisional Leadership teams (typically Divisional Clinical Directors and Divisional Managers with Matrons and Finance leads).

Once QEP schemes have been identified, we review performance every month including a number of metrics relating to Quality, Efficiency and Productivity including those listed below

- Length of stay
- Pre 11am discharge rates
- Bank and agency spend
- Bed occupancy
- Theatre productivity
- Emergency readmission rates within 30 days

Transformational programme

We have appointed a new deputy chief executive to start in June whose key focus will be the further design and implementation of a major transformation programme to underpin delivery of our quality objectives and demanding efficiency savings.

We are scaling up our Lean transformation to fundamentally redesign and improve our services. This will be a long term programme that will require significant change and investment; therefore, work to date has focussed on preparation, research and engaging with the executive team to agree the approach. This work will be strongly integrated with the planned electronic record technological changes and will be supported by a comprehensive OD programme.

The key planks of the transformation programme are likely to be:

- **Flow** - The flow programme was established 12 months ago, and focuses on projects supporting our six flow goals. 1. Every patient on a prescribed pathway known to patients and staff and are cared for in the right clinical environment. 2. Ward rounds occur with a senior decision maker every day with the senior nurse. 3. Medication does not cause a delay for the patient. 4. Need for therapy input does not cause delay for the patient. 5. Patients are given a predicted date of discharge on arrival. 6. We are all working from the same information about our patients.

There will be a specific focus in the first instance on

- the elective care pathway in surgical and gastrointestinal services
- our neurosurgical pathway
- urgent care pathway

- **The “Productives”** - The Productive Outpatient Programme (POP) was launched at UCLH in April 2011. POP is a 24 week improvement programme, designed and delivered by the Trust’s QEP Team. POP aims to engage, train and empower front line staff to redesign and improve their own outpatient services. Plans to scale up the programme are now well advanced to extend delivery of this programme to 80% of our clinics by 2015.
- **“Liberating everyone”**: based on a successful model of “liberating the Sister” to spend more time on direct patient care and leadership, four key processes / corporate directorates are going to be put through a lean methodology
- **Customer experience improvement**: to improve customer service across the whole organisation, building on the introduction of our values and our Making a Difference Together programme of work.
- **Organisational development programme**
- **Technology** - ICT is a vital enabler for many of our projects and we support a range of technological advances that will enhance the outcomes for both our Flow and Productives programmes. Investing in IT and infrastructure to deliver efficiency opportunities is considered a key enabler. Current examples of this include software developments, installing WiFi and purchasing mobile devices. These are key enablers to support the Trust wide patient flow programme as well as smaller Board level improvement opportunities

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 our staff to perform at their very best
- ensure that our people demonstrate the Trust’s values and behaviours to patients
- and each other
- care for the people who care
- work in partnership to deliver innovative, focussed, proven, fit for purpose
- workforce practices
- enable the organisation to deliver its strategic and operational priorities

Our Strategic Workforce Priorities for 2014/15 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
- **Deliver an aspirational approach to organisational development** - increase UCLH's effectiveness and on-going viability, supporting it to adapt to new technologies and an ever changing climate. Develop a vibrant community of leaders at all levels of the organisation who are confident and competent to lead
- **Improve and innovate to deliver excellent 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
- **Support staff with effective education, learning and development** - ensure all our staff have the skills, knowledge and experience to enable them to deliver at their very best for patients, carers, colleagues and for UCLH. Foster a climate where learning and development flourishes and drives improvement in all we do
- **Deliver improvement in key workforce indicators** - drive improvements in key workforce processes across the employee lifecycle

For 2014/15, 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 Plan 2014/15

As part of the 2014/15 planning round each Division and Corporate Function was asked to complete and submit the Workforce Planning templates to confirm planned workforce establishment changes in 14/15. Workforce leads were informed that all changes, with a 75% or more likelihood of becoming effective, should be included in the plan.

This shows that across UCLH there is a net planned workforce establishment increase of 276 wte in 2014/15. The planned budgetary line assumes that this increase will be made consistently over the year. These figures do not currently include the impact of the Pathology Joint Venture.

It should 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 Workforce Performance reports and issues/exceptions discussed at the Human Resources Committee.

Key workforce planning assumptions in our clinical services include:

Neurosciences: opening of a new ward in April 2014, with a requirement of around 16 nursing posts

Maternity: additional staff in maternity across all staff groups, but in particular for midwifery, obstetrics (Consultants and Juniors), Neonatal Nursing and Neonatologist (Consultants and Juniors). This is to deal with anticipated significant growth in deliveries over the next few years.

Cardiac services: the proposal to transfer cardiovascular services from the Heart Hospital to Bart's Health NHS Trust and UCLH becoming a specialist hub for a number of cancers will result in a number of significant staff changes. The cardiac and cancer strategy is still in consultation so detailed plans are not possible at this time.

Cancer Services Division: likewise, in the cancer services division there will be significant staffing change in haematology and radiotherapy as a result of service reconfigurations in London, although these will take a number of years to work through and will only start if / once cardiac services have moved to Barts Health NHS Trust.

Emergency Department (ED): The staffing strategy included in the Emergency Department business case sets out a five year strategy of which the ED is currently in year two. Since the end of the 2013/14 year, there has been recognition that some of this additional staffing needed to be continued, although the department is still establishing funding sources. Staffing levels in the department have been increased to reflect best practice models of care, which include a dedicated Urgent Treatment Centre, increased Majors capacity to avoid doubling up during the busiest periods, a new Clinical Decision Unit, (scheduled to be expanded in 14/15) to avoid unnecessary emergency admissions and the planned co-location of an ambulatory care facility. The strategy allows for Rapid Access and Treatment areas and more effective streaming and triaging of patients in addition to meeting Paediatric care quality initiatives in line with Royal College of Paediatrics and Child Health recommendations. The staff increases allow UCLH to achieve best practice staff to attendance ratios as benchmarked with the Foundation Trust Network hospitals

Clinical Support: Pharmacy and Therapy services have increased staffing to provide "24/7" services for the urgent care pathway in order to improve patient flow over the next 12 months. The changes will ensure improved weekend and evening cover for the hospital, extending the weekend dispensary service significantly and providing more ward based technical support to support ward based discharge and flow.

Imaging: over the next 12 months the Division's operating environment will change, driven in particular by London Cancer service reconfigurations, the installation of a PET CT camera at RFH and increasing

internal demand. In 2013-14 Job plans for medical staff have been reviewed and moved to 8:2 ratio for those in leadership roles and 8.5:1.5 for other Consultants.

Surgical Specialities: a staff consultation is being progressed to adopt 7 day working within the directorate in response to increase in weekend activity. The financial and staffing implications are still being assessed.