



Strategic Plan Document for 2013-14

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

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

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Date	29th May 2013

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name (<i>Chair</i>)	Mike Robinson
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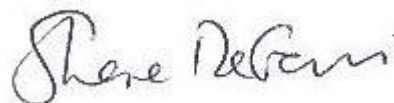
Signature



Approved on behalf of the Board of Directors by:

Name (<i>Chief Executive</i>)	Shane Degaris
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Signature



Approved on behalf of the Board of Directors by:

Name (<i>Finance Director</i>)	Paul Wratten
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Signature



A Strategic Context and Direction

The Trust is currently the provider of the vast majority of the local health economy's acute hospital care, with nearly 80% of our activity commissioned by Hillingdon Clinical Commissioning Group (HCCG). The local health economy has had a turbulent recent financial history. Current financial performance looks increasingly difficult with the next 3 years requiring HCCG to undertake an ambitious financial recovery plan.

Hillingdon Borough's Key Health trends
Although population growth as a whole is low (around 0.6%pa) the majority of growth will come from the elderly segment , implying a greater need for health & social care services
Number of older people with dementia expected to increase by 7% over five years to 2015
High burden of households needing support for physical disabilities, frail elderly etc., and 29% of households with frail elderly members living in housing unsuitable for their needs
Childhood obesity is rising, with 20% of year 6 students classified as obese and likely to suffer from cardiovascular diseases in time
Significantly higher numbers of alcohol harm related hospital admissions compared to England (19% higher for men, 9% for women)

The Trust currently delivers strong operational performance and good quality outcomes. It is also geographically well placed to capitalise on changes to the patterns of patient flows and activity resulting from the reconfiguration of neighbouring hospitals, particularly in relation to Maternity and Accident & Emergency services.

Significant change is proposed to the provider landscape in North West London as part of the "Shaping a Healthier Future Programme" (SaHF). This will see the closure of 4 A&E's with Hillingdon Hospital and other designated major acute hospital sites having to take on the additional workflows.

Only 1 of the other 5 acute Trusts in the sector is currently an FT (excludes CNWL as a community and mental health provider), with 3 of 5 Trusts having a cumulative deficit position (at the end of 2011/12) ranging from £15-60m. A number of formal merger options are currently being explored including Chelsea and Westminster and West Middlesex, and Northwest London Hospitals and Ealing (see table below).

	Turnover	No of sites	11/12 surplus/ (deficit)	11/12 cumulative retained earnings	11/12 Wte staff
West Middlesex Hospital	£148.9m	1	£1.7m	(£15.9m)	1,829
Ealing Hospital	£234.6m	1	£2.2m	£11.7m	3,406
North West London Hospitals	£385.7m	3	(£16.8m)	(£60.4m)	4,370
Imperial College Healthcare	£941.8m	5	(£20.5m)	(£32.9m)	10,067
CNWL	£376.3m	n/a	£13.7m	£20.3m	5,125
Chelsea & Westminster	£342.9m	1	£13.6m	£74.3m	3,301
Hillingdon Hospitals FT	£190.2m	2	(£2.9m)	£25.3m	2,597

The Trust has a number of key strengths as it relates to its competitors, which are summarised below

1. Track record of strong performance – As one of only 3 Foundation Trusts in the sector the Trust has a strong track record of delivery. This is further evidenced by our performance since becoming an FT with a consistent governance rating of Green and an FRR 3. This is in stark contrast to many of our competitors in the sector and surrounding area.

2. Geography and local relationships – The location of our main acute hospital site, which services the vast majority of the local population, provides a natural form of barrier to entry for new market entrants. This is supplemented by increasingly improved relationships with local health and social care partners that is manifested in a number of integrated care schemes, which strengthen our position as the local provider of choice. We are now being recognised as a high quality, value for money provider outside of our immediate locality, which can be demonstrated through the successful bids for GP pathology work in Hounslow (successfully acquired from West Middlesex Hospital as the previous provider)
3. 'Fixed point' as part of the sector reconfiguration – The sector reconfiguration plans to close 4 A&E departments across the health conurbation with the work diverted to other major hospital centres or managed in an out of hospital setting. The Trust has been identified as a future major hospital site, which is fully endorsed by the former SHA and local commissioning organisations.

The Trust does recognise that there are number of potential weaknesses as it relates to its competitors that need to be addressed as part of its long-term strategy. This was also highlighted as part of the APR stage 2 financial stability review undertaken by PwC at the request of Monitor and which the Trust is actively seeking to address.

1. Size and economies of scale – This represents the Trust's biggest challenge, particularly in light of some of the proposed mergers in the sector which, if they take place, will leave the Trust by some way the smallest of the remaining organisations (see table above).
2. Estate – The Trust estate requires modernisation, which presents an increasing challenge to deliver contemporary healthcare as well as servicing the associated maintenance costs. Whilst many of our competitor Trusts have equally challenging estates, we have the requirement to service 2 (Hillingdon and Mount Vernon) sites and have potentially proportionately less capital funds with which to invest.
3. Over-reliance on a single commissioner – The Trust has, unlike a number of competitors, historically received the large majority of its clinical income from a single commissioner. This creates an inherent risk, particularly when the commissioner is financially challenged.

The Trust forecasts that it will continue to broadly retain as a minimum the current market share of activity for Hillingdon patients (circa 75%), with the potential opportunity to repatriate further work as innovative models of care are developed with local health and social care partners. As part of SaHF, the Trust fully anticipates significantly increasing the market share of work from neighbouring boroughs as part of the downscaling of Ealing hospital. We also believe there to be a number of opportunities that will enable the Trust to grow its market share in surrounding boroughs as we look to expand the provision of services such as tertiary dermatology and GP direct access pathology.

It is quite clear that the local health economy faces some very significant financial challenges over the next 3 years. This is driven in large part by the significant deficit (£18.8m) generated by the PCT in 2012-13, and the subsequent recovery plan that the newly formed CCG have agreed as part of their authorisation process. As the main acute provider, a significant proportion of the CCG's recovery plan will impact on this Trust. In order for the CCG to return to a balanced financial position, they are looking to undertake a 3-year, £40m recovery programme. This will look to pull out £13m, £13m and £10m respectively in each of the next 3 years from the Trust. However, as an integral part of the recovery plan there are significant opportunities for the Trust to re-provide services with a value at £6.6m, £8.6m and £6.2m respectively for the same period.

The modelling for SaHF assumes our host commissioner, consistent with their recovery plan, will remove activity from the Trust to be re-provided in a community setting. The model assumes this will generate a financial saving for the commissioner, as well as providing the capacity for the Trust to accept increased activity from Ealing following the proposed changes in the provider landscape. The model also assumes that the contribution lost by the Trust by activity moving out of hospital is offset by the contribution gained on the activity transferred from Ealing, to allow both the commissioner and the Trust to be in financial balance by the end of the process. This is envisaged to have taken place by around 2017/18.

The Trust is concerned that maintaining financial stability during the intervening years may not be possible, as the activity and associated contribution will be lost from out of hospital initiatives before the released capacity is taken up with Ealing activity. The financial impact has not yet been modelled for the intervening years in the SaHF business case, but our concern has been verified by the joint work undertaken on the health economy's behalf by PwC, indicating that the Trust will require

transitional support until the changes anticipated through SaHF are fully delivered. This builds on the analysis undertaken by PwC on behalf of Monitor as part of the APR stage 2 financial stability review. The resource requirements to deliver high quality, safe care in the face of improving standards, a prolonged economic downturn, and demographic changes require a fundamental shift to the Trust's business and service model. To enable us to do this we have 3 areas of strategic focus in terms of growth and service developments:

1. To maintain and grow our status as a major acute hospital in the context of the NW London 'Shaping a Healthier Future' programme.
2. To define and focus on a realistic range of areas where the Trust can develop and expand its service portfolio to meet the health needs of the population we serve and can be delivered in a financially sustainable way (underpinned by the use of service line analysis).
3. To both provide and to be seen as a provider of integrated health care. This supports the need to provide care in the most appropriate setting, and to take advantage of opportunities to integrate pathways of acute and community care.

In light of the above key strategic challenges regarding expansion and overall growth, the Trust has also set out its overarching strategic priorities and the associated objectives for year 1.

STRATEGIC PRIORITIES	OBJECTIVES (YEAR 1)
To create a patient centred organisation to deliver improvements in patient experience and the quality of care we provide.	<ol style="list-style-type: none"> 1. Fully comply with licence to operate/ regulators 2. Improve the quality of care 3. Improve patient experience 4. Improve patient safety
A clinically led service strategy that responds to the needs of patients and other health and social care partners	<ol style="list-style-type: none"> 5. Work with CCGs collaboratively to improve and integrate services within available resources 6. Improve Patient & Public involvement 7. Engage clinicians to develop innovation and expansion of services
To deliver high quality care in the most efficient way	<ol style="list-style-type: none"> 8. Deliver healthcare more efficiently 9. Improve and invest in IT to support service improvement 10. Modernise & reconfigure the Estate & Facilities to meet the needs of our clinical services 11. Maximise staff contribution to transforming the way we deliver our services
To develop sufficient sustainable scale to enable us to improve and grow healthcare services for our communities	<ol style="list-style-type: none"> 12. Develop a service plan in response to SaHF 13. Develop strategic alliances with appropriate partners

The demand profile for services has not seen significant changes outside the national norms. Key and noticeable growth areas have included gastroenterology (as a result of the bowel screening programme) and oral surgery (given changes to the dental contracts). Demographic and non-demographic growth factors have seen a steady and constant increase in demand across both non-elective and elective services evidenced by our overall activity and income increases over the last few years.

We have also seen activity increases in services where we have targeted growth strategies. This is most obviously evidenced from the work we have done to win new contracts in pathology and develop a tertiary service for dermatology.

The Trust's principal approach to diversifying income streams is through a targeted and opportunistic approach to service expansion in a number of focused service areas. This includes pathology, dermatology, urgent care and elective surgery through service expansion and the winning of bids. Secondly, key service areas that will be central to the planned SaHF changes, most obviously emergency care, maternity and neonatal services, will be further developed.

The Trust has also sought to formalise arrangements and a shared vision with both the local CCG and community service provider in the form of joint Memorandums of Understanding. A number of joint Board-to-Board meetings have also been held with the CCG and continue to be planned with both organisations in the new financial year.

The Trust has a number of planned and proposed schemes in place to provide more integrated services with other health and social care partners. The key services proposals are detailed below

MSK

The Trust has agreed with commissioners to implement a redesigned orthopaedic, rheumatology and pain service model from April 2013 with implementation of jointly agreed pathways specifying patient management in primary and secondary care and development of a CATS (Clinical Assessment and Triage Service) model to triage referrals and provide interface management.

Integrated Care Pilot

The vision for the Outer North West London Integrated Care Pilot (ICP) is to improve outcomes for patients by creating access to better more integrated care outside of hospital. The overarching aim of this ambitious and transformative programme is to improve health and social care support for some of our most vulnerable residents. Patient pathways will be redesigned by ICP Partners, with an initial focus on care of the elderly (those individuals over 75 years of age) and adults with diabetes.

This integrated approach is expected to deliver improved outcomes for patients by averting hospital attendances and admissions; reducing length of stay for those patients who are admitted to hospital; improving the patient's experience of discharge from hospital; and preventing readmissions.

Early Supported Discharge (ESD) Programme

The ESD programme aims to support patients admitted for an acute episode by transitioning them back to the community more quickly. This will involve health and social care partners undertaking the following:

1. Proactive in-reach/outreach service managing the transition from acute to community settings.
2. Enhanced care at home / usual place of residence using multidisciplinary approaches to care for up to 10 days.
3. Step down bed facility in the community with jointly agreed admission criteria and processes.
4. Joined up intermediate care service at home / usual place of residence (rehab + re-ablement + home care + telecare + equipment) for up to 6 weeks post discharge from ESD, step down beds or hospital.

Northwest London Pathology Modernisation

Pathology is a rapidly evolving field; modalities of diagnosis are expanding and the necessity to perform multiple investigations on a sample is ever increasing. Furthermore, pathology remains the backbone of innovation and research in medicine, and changes in diagnostics have a major impact on research. Equally challenging, as a result of the Carter review, commissioners are looking to reduce the expenditure on community pathology testing.

In response to these changes, in May 2012 the Trust joined with five other NWL Trusts to carry out a high level options analysis that would assist us in determining the most efficient operating model for the delivery of pathology, whilst improving the quality of the service and increasing opportunities for training and research. Whilst the first phase of this project suggested a model with a single consolidated NHS hub along with local core laboratories at each Trust site, the next phase of the project will look to develop and review this option further, including a more detailed operational model covering all aspects of pathology. It will also consider variations to this option as required by the Trusts, which may have particular needs or areas of specialist focus. This will inform a more detailed business case for further review by each organisation in June 2013. At this point, a decision will be made by each Trust as to whether to proceed with an alliance or partnership should the model prove beneficial.

B Approach to quality

B1 Existing quality concerns (CQC or other parties) and plans to address them

Concern	Action
1. CQC concern: puerperal sepsis	Addressing coding issues Care of urinary catheters
2. 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)
3. LHP standards for Paediatrics, Maternity, Emergency department	In Maternity focus on midwifery ratios and 1:1 care in labour, enhanced hours of labour ward consultant presence In Paediatrics, focus on adequate numbers of trained paediatric nurses at all times in A&E and on early consultant decision making (within 12 hours of admission) seven days per week In Emergency department, a doctor of ST4 (experienced middle grade) or above present at all times
4. National Hip Fracture Database – 11/12 report shows THH to be an outlier for mortality	This was picked up early in 2012, and by improving the percentage of patients having operation within 36 hours (well above national and London average) and appointment of ortho geriatrician to provide more MDT care, the HSMR for this patient group has fallen to 70 (average 100) 2012-13 ytd figures

B2 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 in 2013/ 2014. <ul style="list-style-type: none"> Additional medical and nursing staff out of hours and an enhanced phlebotomy service will now continue on a permanent basis to reduce delays. Additional band 7 supernumerary co-ordinator on duty 8pm – 8am 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. <p>The Trust will continue to work closely with community providers and the third sector to ensure that admissions to hospital are avoided where possible, and that time spent in the department is reduced.</p> <p>Collaborative working through the Integrated Care Pilot will continue to identify patients who are regular attenders and with consent will review care plans on an individual basis using a multi- agency approach.</p>
Failure to meet MRSA or C diff target	Delivery of year 3 of the Infection Prevention & Control (IP&C) strategy Delivery of 2013/14 Healthcare Associated Infection Action (HCAI) plan C diff workshop held in May 2013 with engagement of key stakeholders, including Public Health England. Gap analysis of most recent DH guidance to be completed Increased focus on antimicrobial prescribing
Reduce moderate to severe incidents (SIs)	Key part of Divisional Governance forums, highlight key themes, develop action plans and monitor, report to Clinical Governance Committee

Key quality risks	Plans to manage
Paediatric SIs.	<p>Clear pathway for the initial management and escalation of the acutely unwell child in place, Implement PEWS by Sept 2013.</p> <p>Improve continuity of care (single consultant of the week with no other clinical commitments scheduled now in place).</p>
Rising Hospital Standardised Mortality Ratios (HSMR)	<p>Improve palliative care coding (now improved from 0.4% to 2.3% with national average of 2.5) and co-morbidity coding, working with clinical and coding teams.</p> <p>Identify specialties with high HSMR and understand factors with implementation of clinical changes (e.g. bundles of care) as appropriate. HSMR has reduced from over 100 in 11/12 to 89 (ytd 12/13).</p> <p>Learn lessons from audit of 50 consecutive deaths, as well as Dr Foster workshops with each of the 4 specialties with above average HSMR</p>
Francis Report outcomes	<p>Further embed Trust culture and values (CARES: Culture, Attitude, Responsibility, Equity, Safety) framework with clear measurable outcomes</p> <p>Fully implement FFT especially in A&E where initial uptake below required 15%. Learning from the best- visit planned to London Trust achieving >15%. A minimal daily target has been set and communicated to staff. Completed forms will be collected daily to improve management and action on response rates. Improve staff engagement to ensure that:</p> <ul style="list-style-type: none"> • results are shared across the department • clear responsibilities are established for driving up response rates & taking action in response to the feedback. <p>Publicise "whistleblowing" policy and reinforce open, no blame culture</p> <p>Explore further opportunities for listening to and engaging with staff</p> <p>Launch refreshed clinical quality strategy and updated quality governance framework</p> <p>Deliver Safety Thermometer CQUIN</p> <p>Deliver the new Nursing and Midwifery Quality Assurance Framework</p>
Failure to meet adequate levels of staffing implied in Francis Report due to financial & trained staff constraints	<p>Participation in the NHS London Nursing Productivity Project has given the Interim Director of Nursing detailed information to inform decision making by enabling benchmarking with others who are productive whilst maintaining high quality care (measured across a range of indicators).</p> <p>Working with operational divisions to develop robust plans to pilot the supervisory senior sister's role.</p> <p>Skill mix and staffing ratios will be reviewed twice a year (as a minimum) or when there are significant service changes using the appropriate best practice guidance, evidence-based tools such as acuity and dependency tools.</p>
Number of in-patient falls	<p>Reduction targets set for each ward and included on nursing quality dashboard; overall Trust target to be included on Trust Board quality dashboard. Exception report to be provided as part of quality report to Trust board monthly.</p> <p>Incidence of falls monitored at Director of Nursing performance meetings.</p> <p>Falls reduction action plan to be monitored at Clinical Governance Committee and reported to Quality and Risk Committee</p>
<p>Complaints Management:</p> <ul style="list-style-type: none"> - Failure to achieve target response rate of >90% - Failure to learn 	<p>Complaints/PALS service to merge and for concerns and complaints to be managed in a more timely and responsive way.</p> <p>Complaints action plans to be robustly monitored by divisional governance boards, actions and learning to be reported at Clinical Governance Committee.</p> <p>Complaints/PALS performance report to be monitored by Quality and Risk</p>

Key quality risks	Plans to manage
from complaint themes and to take appropriate action	Committee and exception report to be provided to Trust board alongside new quality dashboard. Learning to be shared more widely across the organisation in 'team brief'.

B3 Board assurance on the quality of services and safeguarding patient safety

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

1. The monthly quality and performance report, which has a separate quality section that highlights quality issues through text and performance indicators. Each quarter this is supplemented with a larger Clinical Quality report which includes items that are not included in the monthly quality performance reports, for example information from NHS Choices and any external / peer reviews, and a summary of performance against KPIs in the Annual Quality Report "Look forward" section.
2. Serious incidents all 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.
3. The Quality and Risk Committee (QRC) is a Board committee, which was formed by the amalgamation of the old Clinical Quality and Standards Committee and the Integrated Risk Management Committee. It oversees a wider range of quality indicators, particularly clinical dashboards from all the hospital divisions. It also carries out a detailed quarterly review of complaints in terms of themes and severity (including a detailed section on "Lessons Learned and Actions taken"); and actions to address medium and high risks. Regular reports to the Board, including exceptions, are presented by the QRC.
4. 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 all 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.
5. All service changes have a Quality Impact Assessment (QIA) reviewed by the Medical Director, and quality concerns are reviewed at meetings attended by all the relevant executives, chaired by the CEO. All complex service changes (e.g. all cross divisional schemes) will have scrutiny by a multi-professional Clinical Assurance Panel (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.
6. 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/matrons or through 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 Trust's Experience & Engagement Group (EEG), chaired by a NED, has a particular role in reviewing patient feedback. 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 the Board quality & operational performance report.

C Clinical Strategy

C1 Overall clinical strategy over the next three years

Our focus is firmly on the delivery of excellent, evidence based healthcare for the best value. Providing a safe and healthy environment of care is an underpinning element, both for patients and for our staff. We will aim to meet all our Department of Health and CQUIN targets for these indicators, the key ones being HSMR, Patient Safety Thermometer, HCAI, and for those where there are no specific targets, we will aim to be in the top quartile of national performance for a set of key indicators agreed by the Board.

As our previous clinical quality strategy ran from 2010-13, this year will see a formal updating of the strategy. As such we have already held a Board Clinical Quality Strategy workshop in January 2013, with a follow up session held in May 2013.

An intrinsic part of our Clinical and Quality strategy over the next three years will be the implementation of the recommendations of the Francis Report. We are currently reviewing our 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, more detailed and patient focussed nursing templates (heat map and observations of care) and establishing further mechanisms for measuring compassionate care as necessary. There will be an additional focus on dementia care where we are seeking to achieve “dementia-friendly hospital” status, and have an action plan and CQUIN in place.

As part of implementing the Francis Report recommendations, we are very clear about the need to develop our ward leaders and instil a culture consistent with our CARES values, so that staff are empowered to report incidents in an open, blame-free working environment.

We recognise that healthcare will need to be provided in a changing landscape in NW London guided by the SaHF programme which will lead to reconfiguration of acute and primary care services in an effort to deliver better healthcare in a financially challenged economy. As a fixed point for delivering 24/7 emergency care, implementing the emergency care standards (London Health Programmes) will be a priority. This will require increased consultant working at evenings and weekends.

SaHF involves increasing out of hospital care, which will involve reducing lengths of stay and reducing hospital readmission rates. The latter in particular continues to be above the national average. To promote more out of hospital and patient-centred care we have commenced work on some ICPs with our commissioners, as set out above, and will develop others in the coming year.

The following five priorities identified in the “Look forward” section of the 2012-13 Quality Report, complement the themes outlined above:

1. Continuing with the Leaving Hospital Project to include work with external experts regarding **Improving Inpatient Care and Discharge**, to enhance early assessments for elderly people and reduce any unnecessary lengths of stay in hospital, as well as reducing readmissions. We will be improving the discharge process by better co-ordination of teams and working closer together with doctors, nurses pharmacists and therapists when reviewing a patient's need before they leave hospital.
2. **Improving Emergency Care** will take into account the Acute Emergency Care Standards that have been set across London and an analysis of the HSMR ratio. There will be a focus on early consultant review of patients requiring admission on a seven day week basis to enhance early senior clinical decision making and eliminate the variability between weekday and weekend mortality.
3. **CARES** using our set of values supported by a framework launched in May 2012 that sets out the standard in terms of attitude and behaviours we expect from our staff.
4. **CQUINs** (Commissioning for Quality and Innovation) will continue to focus on prevention of blood clots, however, we will be expected to achieve a higher percentage of patients assessed. The patient experience CQUIN will be based on the new “Friends and Family Test”. The dementia risk assessment will be continued and the Patient Safety Thermometer will be based on reductions in pressure sores and not just on data submission. Regional and local CQUINs are still to be agreed.

- Continuing with the **First Contact Project** which will further embed the way patients are contacted and reminded about their appointments and to further centralise bookings. The Call Management System needs further development to ensure we are getting our messages right for patients. There will be significant resources allocated to implementing an Electronic Document Record System which will allow easier clinician access to full healthcare records and relevant referral forms, enhancing clinical decision making.

We will continue to focus on clinical quality reporting to the Board with monthly operational reports against key quality targets, and we will continue with our quarterly clinical quality report to the Trust Board, which includes progress against key outcomes in the Quality Report (formerly Quality Account).

We continue to refine the content of our Dashboards to ensure that the relevant indicators are reviewed at each level, and these have recently been refined for the QRC and the Trust Board. We have recently ensured that all Clinical Divisions have a common suite of quality indicators as part of their “balanced scorecards”, e.g. mortality, infection rates, patient experience, Patient Safety Thermometer, antimicrobial prescribing, with additional Division specific ones.

We will continue to consult with our stakeholders, including commissioners, our Governors, Healthwatch and our patients, to help develop our clinical quality strategy, including the need to engage our “hard to reach” groups, an area where we have made significant inroads in the past 3 years, especially in maternity. We are reviewing our in-house communications to ensure that we can engage our staff in shaping and delivering our clinical quality strategy. As part of this engagement the CEO is holding regular open forums for all staff and separately with clinical divisions.

C2 Service Line strategy

The Trust is working to further develop the use of service line reporting (SLR) to improve management decision making. In developing the emerging Trust Strategy for 2013 - 2016, a top level service line review was carried out for each of the operational divisions, with a view to establishing a strategy to expand, retain or contract for each service line.

The on-going development of service line reporting and management is being guided by a working group, the terms of reference for which include:

- Acting as an interface between the operational divisions, clinicians, managers and finance for the development and use of service line reporting;
- Developing the quality and frequency of service line reports so that they are regarded as a reliable and accurate representation of the service accounts and ultimately form part of the standard monthly accounts pack;
- Embedding service line reporting analysis in the Trust business planning and performance management functions ;
- Obtaining comparative information on usage of SLR at other Trusts and organisations to inform best practice at Hillingdon.

The use of service line reporting in business planning processes is being embedded, to ensure that divisions are regularly held to account for the profitability/loss of individual service components. Recent examples of the operational use of service line reporting include:

Medicine Division Activity Repatriation

The Medicine division analysed market data to establish the amount of Hillingdon borough activity being lost to other providers. It combined this analysis with SLR data to select specialties for which activity repatriation would be sought. This led to proposals contained in 2013/14 commissioning intentions for the repatriation of MS Infusion work and gastro/bowel screening activity.

MSK Business Case and Tender

The announcement by Hillingdon CCG to tender MSK services required the Trust to carry out a detailed business review to establish the financial and operational benefits of retaining MSK work. In this instance the division broke down the specialty data to analyse profitability at sub-specialty level. This also revealed the relatively low profitability of spinal work, which has been de-commissioned for 13/14.

Paediatric Unwell Baby Income

The Paediatric specialty had until recently shown a very low contribution to overheads. Analysis highlighted that the Trust was not receiving the appropriate level of Payment by Results (PbR) income for “unwell babies”. The commissioners agreed to start paying “unwell baby” income from Q3 2012/13.

Community Midwifery Reconfiguration

Community midwifery had historically been funded under a block contract arrangement, which delivered a contribution to overheads of just 9% in 2011/12. The Trust is planning a major restructure of community midwifery that will form part of the 2013/14 QIPP program. The intention is to reduce the number of home visits and offer women postnatal clinics and a revamped homebirth service. These changes will simultaneously improve the quality of the service and reduce costs.

Dermatology Service Development Plans

The Dermatology service delivers a healthy contribution to overheads and overall surplus. It has been identified as an area for expansion with the expectation that additional activity will generate the same margins or better. An integrated dermatology service will be developed at Mount Vernon Hospital to include a tertiary service, and the Trust will seek to provide community dermatology services.

Further work will be undertaken in the later part of the financial year to look at the rolling out of Service Line Management as part of creating a more clinically led management function.

C3 Clinical Workforce strategy

Overview of the clinical workforce strategy

The clinical workforce strategy takes into consideration the key external and internal drivers regarding the NHS workforce in general and the Trust workforce in particular, including *Equity and Excellence: Liberating the NHS*, the SaHF programme and the out of hospital strategy which set out the future service delivery and commissioning model for the NHS. The drive to deliver more care in an out of hospital setting through the integration of services across the health economy has to be achieved in conjunction with an ambitious QIPP and financial recovery programme, with increased competition from Any Qualified Provider, whilst at the same time improving the quality of patient care and experience. These factors all have a significant impact upon the Trust's future and the staff who will be delivering those services. Detailed workforce plans will be developed in 2013/14 to reflect the future requirements based on further refinement of the workforce modelling that has already been undertaken.

In addition, the publication of the second part of the Francis Report together with the recent Department of Health document, *Developing the Culture of Compassionate Care* have significant implications for the workforce, reinforcing the need for the Trust to focus not only on the transformation of patient pathways but ensuring we recruit, retain and develop the aptitude and behaviours of the staff involved in delivering them. The Trust has already integrated its CARES values within its appraisal, talent management and performance management processes and is delivering programmes of customer care training for all staff over the next 2 years. A review of the numbers and skill mix of the nursing workforce in light of the recommendations of the Francis Report is one of the key priorities for 2013/14. The Trust is to pilot supernumerary Senior Sister/Charge Nurse roles on three wards in the first 6 months of 2013/14.

The proposed re-shaping of Ealing Hospital through the SaHF programme will have significant implications for the both the Maternity and Accident and Emergency departments in terms of numbers and skill mix with an increased need for paediatricians, midwives, maternity support workers, nurses and A&E consultants. This programme together with the Emergency Care Reconfiguration project will have a significant impact not only on the numbers of emergency attendances but upon the patient pathway, patient experience and length of stay. A detailed workforce plan is currently being developed to ensure that the workforce is of the requisite size and is equipped with the necessary skills to deliver the revised pathway of care. Agreement has already been given to the appointment of two new A&E consultants to meet some of the new Emergency Care standards. The workforce plan will need to be transitional as the flow of patients from Ealing is likely to be incremental rather than immediate. In addition, the UCC is currently being tendered and this will have a significant impact upon the workforce depending on whether we are successful in our bid.

The drive to provide care closer to home will undoubtedly impact on out-patients and the staff who deliver those services. Work is currently underway to redesign the MSK pathway which will see more care delivered in an out of hospital setting, with more input from Extended Scope Practitioners and less reliance on OPD surgery to meet the new CATS model. Ophthalmology will be implementing a community service with an increased demand due to diabetic patients. In addition, the redesign of patient pathways together with the provision of more integrated care and the potential tendering of services will also have a significant impact on the shape and nature of the future workforce. The Trust is currently undertaking a number of pilot schemes as part of the Improving Inpatient Care programme including the Acute Care of the Elderly (ACE) team and an Integrated Care Pathway for elderly patients who have been subject of a fall, which will reduce the length of stay, prevent re-admissions and provide more care out of Hospital. The restructuring of the community midwifery service will also increase capacity and the Trust's ability to support the delivery of more home births at nil cost. Integrating our workforce with primary, secondary and social care will increase over the years, requiring staff with different skills and aptitudes to work in the community, in a multi-disciplinary team and across organisational boundaries.

Further specific future commissioning intentions are yet unknown, however, the CCG has already announced its intentions to de-commission spinal services and the patient pathway and workforce will be re-aligned accordingly to deliver more pain management and no surgical interventions. Nonetheless, the significant QIPP challenges, for both the CCG and the Trust, together with the SaHF assumptions will undoubtedly mean that the drive to provide more care in an out of hospital setting will continue at an increasing pace.

Leadership, management capability and people management are inextricably linked: the delivery of high quality, cost effective services requires high performing staff. We recognise that not all future clinical leaders are currently in management roles and it is core to our philosophy that we are able to develop the potential of our people and use a talent management process to underpin this. A leadership strategy has been developed and is currently in its first year of implementation.

Key workforce pressures and plans to address them

The drive towards providing 16 hour/7 day a week consultant cover (24/7 in maternity) together with a requirement for a consultant assessment within 12 hours and the emerging standards of care e.g. emergency care standards, will present the Trust with significant challenges. Where possible job plans are being reviewed to meet the additional requirements and funding has already been agreed to increase consultant presence in A&E and paediatrics. Further workforce re-modelling is currently being undertaken to ensure that the Trust is better placed to meet these requirements by changing the skill mix and numbers of staff across clinical areas, expanding the role of Advanced Practitioners and developing the band1-4 roles where possible. Rehabilitation is potentially another area where consultant cover may require further expansion and this is currently under review.

At present there are no skills shortages amongst consultant specialities and there are sufficient registrars to provide a pipeline of talent into these roles. In addition, London has the benefit of having 20-30% of trainee doctors in the country, the majority of which choose to remain in London.

The increased births and A&E Attendances outlined within the SaHF programme will be incremental and workforce growth will therefore have to be staggered across the next 3 financial years with a degree of uncertainty as to whether the predicted increase in activity will materialise. All vacancies are reviewed in line with predicted work activity and filled either substantively or temporarily or not filled in accordance with these predictions.

The current midwifery ratio is 1:34 against the former NHS London recommended ratio of 1:30, and the Safer Childbirth recommendations of 1:28. From the 3rd June 2013 the maternity unit will be undergoing a 6 week Birthrate Plus audit using both retrospective and live data. This audit will determine the midwifery ratios required to provide a maternity service at Hillingdon that is staffed in line with the needs of our population based upon the above recommended guidance.

The Trust has also recently participated in a nursing and midwifery quality and productivity benchmarking exercise, commissioned by the former NHS London and undertaken by McKinsey & Co. This identified that the Trust nurse to patient ratios are generally in line with the median with a greater relative potential opportunity for improved nursing productivity in non-ward settings of care than in-patient wards. The report identified that there was a slightly greater proportion of unqualified

staff than peer median in acute patient wards and that in some specialist clinical areas there is a higher proportion of more senior nurses than the peer group.

The Trust will be considering the information provided from the benchmarking exercise, alongside workforce review initiatives that are already underway e.g. patient acuity and dependency assessments. Moving forward the Trust will want to make some decisions about the future staffing mix and ratio model in line with any national minimum standards that may be set, best practice guidelines in accordance with recommendations from the Royal College of Nursing and available benchmarking information. .

The Francis Report recommendations about minimum staffing levels have not been taken forward by the government at this stage. However, the Trust will review its nursing workforce numbers and skill mix and will undertake a bi-annual review of nurse staffing levels. Nonetheless, leadership is a key area of focus and the Trust is piloting supernumerary ward Sister/Charge Nurse roles in three areas which will obviously have a financial impact if taken forward across the organisation.

Workforce plans are currently being developed to identify specific numbers and future skills requirements which will be used to develop future recruitment and development plans and to inform the newly formed Local Education Training Boards of our future commissioning intentions.

An overall reduction in the pay bill needs to be achieved in line with our strategic financial plan. A number of QIPP programmes have been implemented which include a review of non-clinical support workers; benchmarking exercises have indicated that the Trust is an outlier in terms of the number of staff at bands 7 and above and work has commenced to streamline and rationalise these roles. Focus continues on improving workforce productivity and the Trust has employed a sickness manager to reduce sickness absence by an average of at least 2 days per annum. This together with better utilisation of technology such as e-rostering, streamlined processes and more informed workforce planning will reduce the reliance on bank; locum and agency spend as well as improve the quality of care provided. All QIPP schemes are quality impact assessed as described below.

The Out of Hospital programme and corresponding changes to patient pathways could mean that the workforce requirements are not immediately aligned to the new model and there may need to be some transitional arrangements in place for a period of time. However, we are working closely with our partners across the healthcare economy to mitigate against this as much as possible.

Impact of the Workforce Strategy on costs

Detailed workforce plans are currently being developed as outlined above. The planned reduction in spend on the non-clinical workforce, increased productivity, the re-modelling of staff numbers and skills together with increased activities and income will deliver the required changes to the workforce in line with financial plans. However, as mentioned previously the uncertainty around the transition of activity from Ealing may mean that our people resources are not wholly aligned to changes in activity resulting in additional cost to the Trust with no increase in income.

There are no services which lack critical mass at present. Clearly, if the commissioner instigates major changes to other patient pathways the workforce implications and other risks would need to be considered.

D Productivity & Efficiency

Overview of potential productivity and efficiency gains built into plans

The QIPP programme at Hillingdon Hospitals NHS Foundation Trust consists of large cross-divisional transformation schemes and some smaller division specific schemes. The programme amounts to a total of £9.7m for 13/14.

The larger cross divisional schemes all aim to increase productivity in order to improve the patient experience and release excess capacity, the improvement areas targeted include:

- Length of stay, bed occupancy and emergency readmissions – the Improving Inpatient Care project focuses on providing a high quality of care to all inpatients by improving the patient journey and thereby decreasing length of stay (LoS) and reducing the number of beds required. The aim is to improve LoS across all specialties without negatively impacting the current occupancy rate. The scheme focuses on 3 core work streams: Acute Admissions; Ward Based

Care & PASPlus+; and Elderly Care Pathways. The analysis carried out to support this scheme suggests that there is opportunity to remove 41 beds as a result of improved pathways and resulting reduced LoS.

- Theatre productivity – The aim of this project is to improve in-session utilisation to a specialty specific target, this will involve improving pathways and booking processes in order to reduce waste and maximise throughput in sessions.
- Bank and Agency spend – The Medical and Nursing rota efficiency projects focus on improving the management of medical and nursing rotas using e-rostering as an enabler to reduce the reliance on temporary staffing. Another cross divisional scheme aims to reduce sickness levels to a Trust target of 3% and therefore further reducing the reliance on temporary staffing.

Other cross-divisional schemes, which aim to improve productivity and efficiency are:

- Medical Job Planning – supporting delivery of changes to job plans as a result of the changes in theatres and outpatients. This scheme is an enabler scheme which supports the delivery of the medical savings identified through other schemes
- Clinical and Non-Clinical workforce productivity – improving the efficiency of working practices within various clinical and non-clinical workforce areas.

QIPP governance

The Trusts QIPP programme governance has been significantly improved in response to the APR stage 2 financial stability review. In 12/13 the review recommended the Trust put in place a full Project Management Office (PMO) in order to provide a robust governance structure to support the QIPP programme. Historically, the Trust had not managed QIPP projects in a consistent way and also tracking delivery had focused predominantly on financial delivery, which led to reactive management when projects failed to deliver.

The Trust commissioned Newton Europe to set-up a PMO function and lay the foundations for the overall QIPP programme governance. The Trust has started to develop their internal PMO team as part of the handover process from Newton Europe. The Associate Director of Programmes and also a Project Manager are in post and further roles are out to advert.

The key recommendations from the APR Stage 2 financial stability review were: put in place a full PMO; prepare refreshed documentation for all schemes which clearly shows deliverables, savings forecast and action plans; provide a higher quality of reporting to the Trust Board to enable them to gain greater visibility of the schemes and areas of non-delivery in order to hold responsible individuals to account.

The PMO has been setup to provide a framework within which all projects will be identified, planned, delivered and tracked; it provides governance and reporting for performance against these plans. This is a step-change from the historical set up, and is intended to help and support successful delivery. The PMO has been integrated into the Trusts reporting and meeting structures and there is a clear escalation process for the QIPP programme. Consistent programme management documentation is in place and projects are being tracked to core delivery milestones. A set of reports which flag risks to delivery and missed milestones have been developed that will be used by the PMO and by the Board to review progress and ensure that project leads have plans to mitigate slippage. The PMO risk rate projects within a weekly and monthly cycle in order to flag risks to delivery and also to support project leads to put in place mitigating actions to avoid slippage.

QIPP profile

The total for the schemes identified is £9.7m in 13/14, £8.5m in 14/15 and £7.8m in 15/16. These figures are all risk-adjusted. These schemes are all recurrent and are expected to continue delivering for the subsequent periods. The detailed profile is shown in the financial template and top 5 schemes by value in Appendix 2.

The PMO and finance function provide a risk assessment against each scheme and work with the project teams to identify mitigating actions to avoid delays to delivery.

A number of the schemes are transformational rather than incremental, including:

- Improving Inpatient Care which is fundamentally changing pathways through the Emergency Department and transforming the way patient pathways are managed within the hospital. Changes such as these are to be achieved through pathway redesign, ensuring appropriate clinical input at the relevant point in the pathway. This programme of work is supported by implementation of IT infrastructure and management information used to drive fundamentally different behaviours to improve patient care quality, as well as making more efficient use of resources.
- Theatre productivity, which relies significantly on transformational change: the project focuses on understanding all the delays in the system (many of which negatively impact upon the patient experience) and removing/reducing them e.g. reducing the proportion of lists that start late, have long turnaround times, finish late or are cancelled. The programme of work focuses on changing the way in which lists are booked, changing the interaction between teams along the patient pathway to further reduce delays, changing the allocation of lists to ensure that capacity and demand is aligned, and proactively monitoring and tracking planned utilisation against actual utilisation.

QIPP enablers

Clinical leadership and engagement

Each QIPP project has a corresponding Clinical Lead, and all relevant project leads are required to present a Quality Impact Assessment to the Clinical Assurance Panel for appropriate quality risk assessment and feedback. Individual projects have communication plans which include clinical engagement and a number of clinicians are involved in delivery through project teams.

Enabling investment

There has been investment into a number of areas to support all aspects of the QIPP programme, the main areas of investment are listed below:

- E-rostering – There has been investment in resource to support the roll-out of e-rostering to improve rota efficiencies and therefore reducing temporary staffing spend.
- PASplus+ / Electronic white boards – The Trust has invested in Newton Europe to support the Improving Inpatient Care project. Newton Europe have developed a system which interfaces with the Trusts PAS system and shows live inpatient data and patient status to allow ward teams to manage patients in a more proactive way. .
- PMO set-up support / Substantive PMO.
- Transformational delivery support –Newton Europe are supporting delivery of two high value and complex schemes; Theatre Productivity and Improving Inpatient Care.

Quality Impact of QIPP

The governance framework also embeds a Quality Impact Assessment (QIA) process as part of the work-up of the schemes. The Clinical Assurance Panel (CAP) scrutinises the QIPP programme and provides assurance to the Board that due consideration has been made to any potential clinical or quality impacts, and that a clear plan is in place to mitigate such risks to an acceptable level. It monitors key quality metrics and acts to mitigate any potential clinical or quality risks which develop, reporting any concerns and actions taken to the Board.

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

- Scheme is scoped by divisional teams
- 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

90% of schemes have now been through the CAP review process and most have come out with outcomes a, b or c.

E Financial and Investment Strategy

Over the 3 year period of the plan, the Trust's financial strategy is to maintain a financial risk rating of 3 under the existing Compliance Framework metrics and the new continuity of services Risk Assessment Framework. It will aim to support the required capital investment to deliver the Trust's estate strategy and the service investment required to develop clinical standards.

In this context the Trust will work closely with Hillingdon Clinical Commissioning Group (HCCG) to jointly develop new pathways of care in line with its out of hospital strategy agreed as the local implementation of the SaHF programme. Over the next 3 years this is designed to clear HCCG's current £20m deficit, whilst maintaining the viability of the Trust as a major hospital fixed point. It is expected that alignment with commissioner plans to support delivery of SaHF will trigger additional local health economy funding to assist with managing the 3-5 year transition and help to significantly mitigate the financial risks associated with the major service changes planned.

To resolve the Trust's 12/13 £1.9m deficit (1% of income and expenditure), additional efficiency savings to those required from the national tariff will be required to be delivered in 13/14. Over the 3-year period of the plan, total savings of nearly £30m, an average of 5.3% per annum and 1.3% more than the national tariff requirement, will have to be achieved. This is a 50% increase on the current delivery rate of savings.

In preparing the Trust to be able to achieve and manage the inherent risks in what is a significant step-change in performance, investment has been made in the much strengthened PMO. A key part of the delivery strategy is that savings plans have been re-focussed on fewer Trust wide transformational schemes with higher yield potential. This will allow the savings programme to be more closely aligned to strategic objectives as well as enabling greater operational delivery and performance management focus.

Having returned the Trust to recurrent balance at the end of the 13/14 financial year a surplus before exceptional items of around £1m in both 14/15 and 15/16 is being planned based on a broadly similar and consistent set of financial planning assumptions.

In 13/14 the Trust is planning to invest £1.5m in quality improvements. It is important over the next 3 to 5 years the Trust continues to invest in its services to be able to meet SaHF required clinical standards in line with its major acute hospital status. In addition, a £0.9m revenue cost from the Trust's £16.5m capital investment programme in 13/14 has also been planned. Funded from a mix of cash and public dividend capital, the investment programme has the Trust's physical infrastructure at its heart. In particular it will deliver a complete reconfiguration of front-end emergency care facilities and continue to reduce high-risk estate backlog maintenance.

Maintaining cash resilience will also remain critical over the 3-year Forward Plan horizon. The Trust ended the 13/14 financial year with £3.9m of cash but around half of this was required to fund capital expenditure slipped from the previous financial year. Therefore, the Trust will continue to work to reduce receivables but will also endeavour to make arrangements with North West London commissioners that will support improved in-year cash flow. Specifically, the healthcare contract agreement reached in 13/14 with NWL CCG's will significantly reduce the Trust's cash exposure risk relating to time-lags and challenge processes associated with large over performance invoices. By the end of 15/16 the Trust is planning to increase its cash balance from £3.1m in 13/14 to £5m.

F Membership

Membership size

2012/13

The Trust had 7,171 public members and 3,081 staff members at 31 March 2013. In September 2012, the Trust purchased a new membership database which highlighted upon installation 211 records for public members who had passed away, were duplicates or where data was incomplete,

effectively reducing the membership to 7,093. Similarly, a discrepancy in the list of staff members was discovered. The total staff figure includes Trust volunteers and temporary bank staff.

2013/14

The Foundation Trust has agreed a target of 7,400 public members by March 2014. Plans are in place to achieve and sustain this target. Staff membership is estimated to remain at the 31 March 2013 level. The Trust continues to recruit volunteers who automatically become staff members after 12 months voluntary service.

Membership Analysis

Age

Over the last twelve months, the number of working age members has increased although there is still low representation in the 16 to 39 age groups. The Trust will therefore continue to recruit members using our maternity and paediatric services and approach local businesses, schools and colleges.

Gender

There are more female members to male members. The Trust will focus future recruitment on improving the number of male public members.

Ethnicity

The categories showing the lowest representation are: White Irish, Asian or Asian British (Indian) and Black or Black British (Caribbean). There are 578 members with missing ethnicity data, which may contribute to some of the under representation. The Trust will target these underrepresented groups to increase membership.

Socio-economic

There is good representation across all the socio-economic groups. The largest number of public members falls into socio-economic groups ABC1.

Disability

There are 772 public members who have been recorded as having a disability. The type of disability is not known for the majority of the members as the Trust has only been able to capture type of disability since September 2012.

Membership Plan

2012/13

During 12/13 the Trust did not conduct any large recruitment drives but instead focused on providing opportunity for Public Governors to engage with their membership. The Public Governors have been joined by the Head of Patient and Public Engagement at all events and together have recruited public members. A number of new members have been recruited at our bi-monthly People in Partnership meetings, annual Open Day and local forums and conferences. Membership forms have been distributed to local shopping centres and libraries. Trust staff continue to attend wards and departments in the hospital to speak to patients and visitors about Foundation Trust membership.

2013/14

A second year action plan to deliver the Membership Development and Engagement Strategy was agreed at the Council of Governors meeting on 25th April 2013. The action plan will include the following actions for improving representation in all age groups, but specifically in the 16 to 49 age group and across all ethnic and socio-economic groups:

- Utilise existing publications, local groups and local events
- Attend local community and voluntary group meetings
- Attend joint public engagement meetings with Hillingdon CCG and CNWL NHS Foundation Trust
- Attend regular 'speak easy' carer events
- Promote membership at Trust engagement events
- Organise membership recruitment events at Hillingdon and Mount Vernon Hospitals specifically targeting patients of working age
- Encourage Governors and members to sign up family, friends and members of the public
- Invite ex-staff, their family and friends to become public members