Operational Plan Document for 2016/17

Royal Free London NHS Foundation Trust
Draft Operational Plan for y/e 31 March 2017

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

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Date: 18 April 2016

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) | Dominic Dodd
---|---
Signature

Approved on behalf of the Board of Directors by:

Name (Chief Executive) | David Sloman
---|---
Signature
Approved on behalf of the Board of Directors by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Caroline Clarke</th>
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<td>(Finance Director)</td>
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1. Planning approach including activity

1.1 Routine trust process

The Royal Free has a systematic and routine process for activity planning. Its components are:
- an annually updated PEST analysis, discussed by the board;
- a board assurance framework of strategic risks, reviewed by the board quarterly and by board committees more frequently;
- a set of quantified and multidisciplinary (demand and activity, finance, workforce) and evidence based planning assumptions, that are updated regularly, including always each winter for the forthcoming annual plan, and at other times as required;
- derived from the planning assumptions a full five year activity model at the level of site, specialty, type of activity, method of admission etc.;
- an annual planning letter sent to all commissioners each September that sets out the main service changes envisaged in the year ahead; and
- full details in the covering letter to contract offers to all commissioners of all growth and other change assumptions incorporated in the proposed baselines.

The trust believes strongly in using the relevant evidence on which to plan future activity. For example we have not in the past brought into our plans the various local Better Care Fund assumptions for reductions in emergency admissions, and indeed they have proved to be very unreliable; and the growth patterns for several of our specialist services are unique to either the developing patterns of incidence and prevalence or to our service model.

1.2 Engagement with commissioners

Especially as responses from commissioners have in recent years been left until the latter stages of contract negotiations, the trust warmly welcomes the expectation that the dialogue about activity assumptions must be earlier and far more realistic. Contract baselines should no longer be significantly reduced for artificial reasons, especially as some commissioners have in the past treated the sum of those baselines as their expected outturns. Therefore we have this year added to our routine processes, as described in 1.1 above, additional meetings with and letters to commissioners to ensure that they have every opportunity to consider and respond to our assumptions.

At the time of writing discussions continue with Barnet CCG about the most likely ranges of activity outturn in 2016/17. The parties are agreed that, especially for cancer and certain investigations, demand is increasing (see paragraph 1.3 below) but the extent to which commissioners’ demand management schemes will be effective in 2016/17 remains uncertain.

1.3 Additional features of 2016/17 planning

Growth in demand at levels not seen for many years is the most important planning problem for the NHS, closely followed by shortages in some key resources such as certain clinical staff and post acute packages of health and social care. For the current emergency demand at Barnet Hospital alone some 40 more beds are needed across the year, although only a proportion of those should be acute beds, the rest being for active rehabilitation that can be sited elsewhere; that figure is liable to rise naturally over time, faster if limited post acute resources lead to longer mean lengths of stay. For example in December 2015 and January 2016 there were on average 130 general and acute beds in this trust occupied by patients that did not need an acute hospital bed.
Patterns of referral are changing significantly. As GPs are incentivised not to refer for a consultant opinion, they are instead increasing their use of direct access investigations, which puts additional demand on those diagnostic services that lack the benefit of expert triage. For example there are now 200 GP direct access requests per day in this trust for non obstetric ultrasound, a 31% increase over the last two years; and the number of two week wait referrals has increased by 72% over the past four years. These kinds of increases have to be abated by the incentives being properly balanced, for example by following standard clinical pathways for investigation, triage and referral, and by 2016/17 we will be trialling dozens of such pathways across Hertfordshire and some north London CCGs. The planning assumption is that these demands will not further increase, but the June 2015 NICE guidelines on cancer referral (that mainly affect the timelines of activity, rather than necessarily its absolute quantity) risk proving that assumption wrong.

The pressure on emergency hospital services over the current winter was predicted by the trust and discussed at the local system resilience group, but unfortunately commissioners invested this winter only about a third of the funding compared with in 2014/15. We have proposed to local CCGs that an objective evaluation of winter resilience schemes and of all the many Better Care Fund schemes must be undertaken in 2016/17 so that the funding that CCGs and local authorities hold are deployed optimally.

The trust’s RTT demand and capacity model has been supported by commissioners and will continue to be in use until the trust reaches the RTT standard half way through 2016/17.

Performance trajectories

As part of the efforts supporting system alignment we have been in productive conversations with our lead CCG on activity planning and key STF trajectories, which we have considered to be a helpful exercise, though the choice of national reporting currencies and data definitions has, in our view, under-stated the levels of activity carried out by the trust – the differences between SUS SEM and SLAM, or SQL and DM01 can be significant. To give one example, for endoscopy, the 2016/17 plan based on DM01 gives 16,813 whereas using internal data we reach a figure of 22,415.

To accompany the trajectory figures we wish to offer specific commentary or caveats outlined in the return as follows:

We have made significant progress on the diagnostics target and are forecasting 99% for 2016-17. However, it is our view that this trajectory can be sensitively and adversely affected by factors outside the trust’s direct control – for example, the actual impact of GP direct access. We have also assumed that this trajectory agreed with commissioners will be funded.

The cancer and RTT figures for April and potentially May are likely to be impacted by the industrial action taken by doctors in training; we have revised the cancer trajectory downwards for these months.

Achieving the A&E four hour wait target of 95% throughout, that is to say in every month of, next year, remains our aspiration, but the evidence at present is that the factors that caused extensive failure of that target during the late autumn and winter of 2015/16 have not been mitigated for 2016/17. Those factors include:

- more demand on hospitals’ emergency services, for example in this trust the 2015/16 demand increase of the 2014/15 level by 4.9% (due to a variety of reasons, but including more very elderly people with multiple conditions);
- extreme pressure in all other parts of the local NHS (especially primary care, the ambulance services, all neighbouring hospitals);
- reduced winter pressure funding compared with 2014/15 and earlier years; and
- forecasts by local authorities of reduced spending power of packages of care compared with the current year.

The projected A&E performance trajectory for 2016-17 assumes that a series of variables beyond our immediate control would be favourable, and in three critical areas outlined below, the following would be true:

**Attendances**

No increase in attendances, certainly no more than a 1% increase in attendances. Factors that could affect this include a comparably benign winter to that of 2015-16 that doesn’t put upward pressure on demand in 2016-17. We would also need to be assured that the fragility of the North London A&E system is remedied substantially given the inter-dependency of our performance with that of neighbouring providers. On that note we have been informed by NHS England (London) that plans are being put in place to support A&E performance in our surrounding geography, though we have not seen these. These plans will need to be sufficient, realised and sustained to give us the opportunity of improvement in 2016-17 over 2015-16; and of course we will look to play a full part in achieving improved system resilience.

**Ambulances**

An improved trajectory in line with both system expectations and our preference could be better enabled if there is system progress on intelligent conveyancing and treating RFL as one site for this purpose. This was agreed in principle last year; giving this agreement effect would undoubtedly support efforts to meet the higher trajectory.

In discussions on the alignment of plans, NHS England (London) has offered to facilitate improved co-ordination between our two ambulance services which is a welcome step.

**DTOCs**

Attaining the trajectory will be contingent on progress being made on a number of fronts in the wider system, such as primary, community and social care managing care outside of a non-elective setting. We note that the commissioner plans we have been working with to date have no specific demand mitigations in respect of A&E.

Looking at DTOCs and also patients medically fit for discharge as a measure of what could help support achievement of an 89% Q4 A&E figure, we would suggest that these should equate to no more than 5% of general and acute beds; the figure is presently around 15% which suggests a system wide effort to reduce these by 10%.

**Vanguard**

The trust’s value proposition for its new models of care vanguard bid was submitted on 8 February 2016. This outlines the proposal for the development of a group model comprising 10-15 hospitals operating under a single group board. The intention of the group model is to improve clinical outcomes, patient safety and patient experience by reducing variation across the group. Changes will be made to the trust’s governance arrangements from 2016/17 to enable the development of the group board.
1.4 Trust annual objectives

Our annual objectives are shown below.

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<thead>
<tr>
<th>Annual objective 2016/17</th>
<th>Related governing objective/s</th>
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<tr>
<td>Implement our organisation wide approach to quality improvement to provide better services of better value for patients.</td>
<td>Patient and staff experience; Safety and compliance; Excellent value</td>
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<tr>
<td>Reduce delays in the pathways and improve the flow of patients through and out of our hospitals.</td>
<td>Patient experience; Safety and compliance</td>
</tr>
<tr>
<td>Improve the recruitment and retention of staff and make the organisation a great place to work.</td>
<td>Patient and staff experience; A strong organisation</td>
</tr>
<tr>
<td>Focus on operational improvement and efficiencies which will help us reduce waste and variation.</td>
<td>Safety and compliance; Patient and staff experience;</td>
</tr>
<tr>
<td>Serve our patients well by being as inclusive as possible and providing strong role models for staff.</td>
<td>Patient and staff experience; A strong organisation</td>
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1.5 Business planning process

The trust’s business planning process is being strengthened this year to encourage individual services to produce one year operational plans for 2016/17, and during 2016/17 develop three year strategic business plans covering from 2017/18 onwards. This approach will help to ensure co-ordinated service plans designed to deliver appropriate, high quality and cost-effective services for patients on a sustainable basis, with a stronger emphasis than in previous years on workforce planning.
2. Approach to quality planning

2.1 Organisation wide improvement methodology

Developing and implementing an organisation wide approach to quality improvement is one of the trust’s five key annual trust objectives for 2016/17 and beyond. The board approved a revised quality strategy in November 2015. It focuses on developing and embedding into daily practice a consistent approach to continuous quality improvement across the whole trust. We are now focused on developing and resourcing the operational plan to deliver the strategy, in the context of RFL forming a hospital group under the NHS England Vanguard.

Our improvement approach centres on equipping front-line staff with the will, capabilities and infrastructural and leadership support to focus on continually improving their work, in parallel with doing the job. At the centre of trust’s approach is the Plan, Do, Study, Act (PDSA) methodology, linked to the API/IHI model for improvement to enable staff to make sustained, incremental progress against aims which matter most to patients. Our approach builds on proven methods which today exist in pockets (for example, our work on sepsis begun in the Royal Free Hospital emergency department and now being extended across the trust). We plan a series of tiered capability-building initiatives to take staff from improvement-aware to improvement-expert, to build a cadre of improvement coaches and “champions”, to ensure our leaders are effective leaders for improvement, and that our information systems provide the necessary data capture and analysis.

This approach to improvement applies not only to clinical quality, but also to clinical support and non-clinical services, and to improvement in the use of resources. Over time our aim is to place ever greater focus on continuously improving value, maximising health gain and outcomes for patients per unit resource consumed.

2.2 Focus on leadership

The trust focuses on maximising the impact of leadership – clinical and non-clinical. We have a range of leadership development offerings, most multiprofessional, from early career “leadership of self” through to executive level. We place particular focus on boosting our capacity in and the effectiveness of our clinical leadership. We have introduced a service line, team based leadership programme, linked to implementing measurable improvements taught by Prof Richard Bohmer from Harvard. Embedding leadership for continuous improvement is at the core of our quality strategy. As we develop our quality improvement process, we are placing specific focus on developing leadership (to board level) with the skills and attitudes required to lead for improvement. We have implemented the AoMRC’s guidance regarding the responsible clinician using visible management: the responsible consultant and named shift nurse are displayed on whiteboards at patients’ bedside.

2.3 Our QI governance systems

Our quality governance systems are aligned with Monitor’s and the CQC’s guidance and requirements. We revised these following our acquisition of the Barnet and Chase Farm trust in 2014: enhancements included substantially increasing resourcing of patient safety, and establishing senior posts in governance and risk across each of our four divisions (reporting to the divisional director of nursing). We have also substantially enhanced our monitoring and reporting systems, including implementation of DatixWeb which is now able to provide feedback to staff reporting incidents. Three board committees focus respectively on patient safety, patient and staff experience and clinical performance (effectiveness). A clinical governance and clinical risk committee integrates governance review across each of the four divisions, and reports to the relevant board committee. We aim increasingly to link governance to improvement with ever greater recognition of and action on risk at local service/ward level, linked to improvement activities and effective learning transfer both within and across divisions. We are currently revising these arrangements to ensure our systems will be fit for purpose across a larger Royal Free Group.
2.4 Our quality priorities for 2016/17

Each year we set out three quality priorities in our Quality Account linked to our five governing objectives. We are in the process of consulting with patients, staff and external stakeholders regarding the focus areas for 2016/17 and will finalise our selection by the end of May 2016. We recognise that delivery against the most important quality objectives often requires a focus lasting several years, and we anticipate that two of our current quality priorities will remain for 2016/17: delivering a world class patient experience (where our aim is to be in the top 10% nationally), and our focus on safety (where our aim is to halve current levels of avoidable harm by 2018 and to be a zero-avoidable harm organisation by 2020). Our third priority may centre on dementia.

2.5 Sign-up-to-Safety (SutS) priorities for 2016/17

Our three year patient safety programme (PSP) deploys improvement methodology and emphasises continuous learning and improvement over time. The PSP implementation plan is based on our SutS pledges and is directly linked to the patient safety priorities in our quality account. The goals for delivery by the end of the PSP in 2017/18, and our priorities for 2016/17, are:

(i) safer surgery – improve compliance with the 5 steps to safer surgery to 95% and reduce the number of surgical never events;
(ii) falls prevention – achieve 20% reduction in falls per 1000 bed days as measured by incidents reported on Datix;
(iii) Acute Kidney Injury (AKI) – increase the number of patients who recover from AKI within 72 hours of admission by 25%;
(iv) (a) deteriorating patient – reduce the number of cardiac arrests to less than 1 per 1000 admissions; (b) deteriorating unborn baby – reduce the number of claims relating to deterioration of the unborn baby to 2;
(v) sepsis – reduce severe sepsis related serious incidents by 50% across all sites in A&E and maternity.

2.6 Quality impact assessment (QIA)

The trust has a robust QIA process for all of its QIPP programmes to ensure that the delivery and planning of any QIPP scheme equally assesses the quality impact (both potential detrimental impact and positive impact) as well as the financial benefit.

The QIA process begins as part of the project initiation and has been embedded into the Project Initiation Document (PID) to ensure that all schemes are reviewed for their impact on quality during the initiation and planning phases. The PID includes a section on project benefits which includes those related to quality, and asks four key questions around the risks to quality:

- what is the potential impact on patient safety?
- what is the potential impact on clinical effectiveness?
- what is the potential impact on patient experience? and
- how will quality impact (as identified above) be monitored and tracked?

Quality impact is reviewed at multiple levels, initially via the local specialty team, then via the divisional team which includes the divisional director, divisional director of nursing and divisional director of operations. It is then reviewed via the QIPP team to provide initial objective scrutiny. High risk schemes (as identified through the risk rating process) are then reviewed via the Clinical Advisory Group (CAG) and either approved, further information or mitigations requested, or not approved. The number of schemes which are not approved by the CAG is minimal due to the review process which occurs via the divisional team and QIPP teams.
The medical director and nursing director conduct a high level review of schemes four times during the year; February, March, June and August. This ensures schemes are reviewed during development. At this stage they may ask for further information or refer the scheme back to the CAG with further questions.

The board is provided with a quarterly update which in Q4 highlights the number of schemes, the groupings of scheme opportunities, the annual plan for QIA and lessons learnt. In Q1 and Q2 an overview of the key themes, the overall risks associated with the programme, and the outcomes of the QI process are presented and reviewed.

2.7 Seven day services

The trust has undertaken a preliminary self-assessment exercise to review the extent to which services are provided seven days a week. The review was undertaken against national clinical standards, specifically time to consultant review, access to diagnostics, access to consultant directed interventions and ongoing review.

As part of the trust’s strategic patient safety programme there is a need to clarify, strengthen and harmonise across sites the processes and capabilities that ensure we are delivering optimal levels of patient safety. These relate to medical staffing at night, including team working across professional groups, medical review at weekends, site and ward level safety briefings and our generic escalation policy. A 24/7 medical cover working group has been set up and consists of the following workstreams: overnight medical cover and team working, site patient safety briefings, ward safety briefings, 7 day consultant review and escalation. The trust is mapping medical cover provided by junior doctors and is identifying when handover meetings take place within each speciality, as well as opportunities to merge with trust wide handover meetings.

The trust executive’s change programme board prioritises and co-ordinates the various change programmes in the trust. This will include a review of the medical staff rotas, which will identify the resource implications for 24/7 medical cover.

2.8 Top three risks to quality and mitigation plans

We have just undergone a full CQC inspection during the week 1-5 February 2016. We see the top three risks to quality as follows:

- **Data capture, analysis and feedback:** We aspire to provide all clinical teams with relevant, reliable, timely data around which they review and monitor their service’s results. This data should be captured where possible through routine care, and be analysed and fed back in actionable format to teams, highlighting variation and trends over time. In our work toward a group model we will substantially increase the effectiveness of our systems and scale and scope of our analytic capabilities.

- **Demand and activity pressures:** Our activity continues to rise to unprecedented levels. We are focused on addressing cancer 62 day, two week wait, RTT and A&E performance. We face challenges in recruitment and retention of staff, most importantly in nursing, midwifery and therapies. Our recruitment and retention improvement plan includes better linkages to Healthcare Environment Inspectorates (HEIs), provision of more structured career development paths for staff and targeted overseas recruitment. Working with local partners, we seek to redesign care pathways, improve discharge and out-patient flow, as well as implement initiatives to reduce flows to hospital through patient and referrer education and better prevention/long term condition management.

- **Financial pressures:** We are addressing our financial challenge by encouraging all staff to focus on value and identifying and removing waste, through specific initiatives to target costs (for example, in procurement and a pathology JV), guided by the Lord Carter review.
3. Approach to workforce planning

3.1 Workforce planning process

The board assurance framework identifies ‘workforce stretch’ as a significant challenge for the trust as the NHS undergoes transformational change and contends with workforce supply issues. To help address this challenge the trust’s approach to workforce planning is being strengthened this year, building on the approach used for the workforce plan incorporated in the business case for the Chase Farm Hospital redevelopment.

3.2 Links to clinical strategies

The workforce plan will take account of the trust’s clinical strategies, the emerging sustainability and transformation plan and will be aligned to our vision 2020 programme. For example the discharge improvement programme is reviewing ways to help reduce length of stay with more advanced technology and this will affect how the workforce operates. Another workstream is the redesign of out-patient pathways, the aim of which is to help reduce demand in the hospitals, that will need to be considered in the annual job planning process.

3.3 Local workforce transformation programmes and productivity schemes

The trust’s workforce improvement programme begun in 2015/16 and reports to the executive change board. Six local workforce transformation programmes are being progressed through the workforce planning and productivity group, as part of the vision 2020 programme. These are:

1. recruitment;
2. retention;
3. nursing productivity and planning;
4. medical workforce planning and productivity;
5. transformational roles; and
6. allied health professionals.

Targeted work has been done in 2016 to scope the key programme milestones within each of the six workstreams. It is expected that the workforce improvement programme will have the following impacts:

- reduction in turnover rate;
- reduction in vacancy rate;
- reduction in sickness absence rates;
- reduction in % pay spend for temporary staffing;
- improvement in medical productivity; and
- numbers of new / extended roles introduced into the workforce.

Actual expected reductions will vary across staff groups and within services, however the intention is to achieve the trust level targets for vacancy (11%), turnover (13%) and sickness absence (3.4%). Agency reduction is an integral part of all programmes.

As the programmes are long term, complex and require a cultural shift for the organisation, it is not envisaged that the impact will be realised in 2016/17, however improvements should be seen from 2017/18 onwards and will be monitored closely.

All workstreams are focused on improving the utilisation of the workforce to support productivity (in line with QIPP). The workforce planning and productivity group oversees all projects and QIPP schemes related to workforce. These include:
development and oversight of the trust’s workforce plan including the development of new roles and new ways of working;
• non clinical support services project/Vanguard group model programme/shared services;
• trust wide policy reviews to improve efficiencies eg establishment control, e-rostering, flexible working etc;
• initiatives to support recruitment and retention;
• sickness absence management including ESR self-service;
• bank, agency and fixed term contracts usage;
• job planning (job plans are effective to aid maximising medical productivity);
• employee benefits/salary sacrifice; and
• appraisal compliance and incremental pay progression.

Further detail of the workforce QIPP programmes is included in section 4.5.

3.4 E-rostering

E-rostering utilisation is part of the nursing productivity and planning work. The monthly e-rostering programme board has been established and is working towards introducing a single, harmonised e-rostering, SafeCare and Bankstaff system across all areas within nursing and midwifery at all trust sites. Health Roster’s complete integration with the Bankstaff system will give total real time visibility of the whole nursing staff resource. This will enable delivery of increased efficiency, greater transparency and safer staffing assurance.

The programme will extend to other staff groups once nursing implementation is compete.

3.5 Safe Staffing

Aligning our resources to patient care has a proven major impact on the quality and safety of care provision, which will help us meet the safe staffing challenge. Safe staffing enables the established and evidenced links between patient outcomes and whether the trust has the right people, with the right skills, in the right place at the right time.

Demonstrating our control of resources is a key component of maximising the use of our workforce, meeting NHS England’s monthly safe staffing reporting requirements, and ensuring we can view and audit our clinical teams in real time. Quarterly acuity reviews take place within the trust, the results of which are monitored at divisional boards.

3.6 Agency

We have assessed ourselves against NHS Improvement’s best practice advice in respect of agency spend, and we are working with local trusts to make improvements in this area. The trust is looking to achieve a 50% reduction in agency spend by 2016/17 to comply with Monitor’s agency cap of £28.976m, although that aim will be put at risk should demand continue to increase as it did in 2015/16. As well as improved recruitment the introduction of a managed e-rostering system will help manage agency staff levels and a specific action plan is underway to support reductions. This includes weekly monitoring of agency usage across the trust by the trust executive committee, tracked against a forecast that has been set to meet the Monitor cap. To achieve the Monitor target from April 2016, agency usage will need to reduce by 40%.

At operational management level, divisional panels meet weekly to consider and challenge bank and agency requests. Any non-clinical posts approved by divisional panel are then submitted to the deputy chief executive for final approval. A number of initiatives focused primarily on recruitment interventions and retention have been
implemented collaboratively between senior management, workforce and finance teams in parallel to support agency reductions. Further education and retention schemes are being developed.

As the largest staff group, retaining nursing and midwifery workforce remains key. Accommodation loans are being offered to support employees to manage the cost of living in London. In-house development programmes are being devised to support career progression eg in theatres, and the education directorate are working with some services to get in-house courses accredited. Retention initiatives for other hard to fill posts are being developed eg sonographers, occupational therapists, ODPs etc. Staff retention will be a key focus of each of the six work streams within the workforce improvement programme.

Trust wide retention initiatives include the 2015-2020 Staff Experience Enhancement Plan (SEEP) which has specific areas of focus including leadership and development, staff health and wellbeing and staff engagement. THE SEEP is currently being reviewed following the release of the latest staff survey results, alongside other data including staff FFT, exit interview analysis etc.

3.7 Education and workforce development

The focus of the education and workforce development committee includes developing new roles and extending existing roles to ensure we have a suitably skilled workforce for the future. One such new role is the physician’s associate role. The group is responsible for overseeing the development and implementation of a plan for the training of physician’s associates within the trust and for their successful introduction into the clinical workforce.

Through the Chase Farm workforce planning process, a small number of other new roles have also been identified. The trust’s education team is currently progressing plans for all clinical and non-clinical roles, to plan and implement education and training supply routes for these roles in addition to where changes have been identified for existing roles.

The trust has an effective working relationship with the Local Education and Training Board and is collaborating with Health Education North Central & East London (HENCEL) regularly to ensure our workforce supply needs are met within the future years.

The following benefits aim to be as a result of business planning:

- further reductions in agency and bank usage over time as a more planned approach is adopted;
- with a standardised approach skill mixes will become more consistent over time with consultations planned in to make changes where required;
- new roles, extensions/changes to existing roles will be mapped as part of the workforce planning process, including the need for detailed implementation plans with regards to staff training programmes and formal consultations required;
- managers/budget holders will be asked to identify their QIPP/efficiency schemes for the next year when thinking about the workforce requirements;
- managers will be more informed with regard to the profile of their workforce to allow better succession planning for “difficult to recruit” to roles;
- job planning approach for consultants will be incorporated into the business planning process (team based job planning/introduction of job planning to other staff groups); and
- all workforce plans will be linked to the trust’s strategy to ensure staff are aware of how their role contributes to delivery.

As outlined in our vanguard value proposition, in 2016/17 the trust will develop a Royal Free Teaching and
Learning Academy that brings together all areas of teaching and learning from across the organisation into a central learning function. Subject to vanguard funding, this will allow investment in centrally produced content and curriculums covering all postgraduate and undergraduate teaching, delivery of statutory training, transformational and improvement related training and leadership development.

3.8 Workforce risks

As noted in section 3.1 workforce stretch is identified in the board assurance framework as a strategic risk to the trust. A workforce risk register is monitored regularly. The key risks at present are delays/difficulty in the recruitment process, industrial action and dispute, and staff shortages causing high reliance on temporary/agency staff. Actions are underway to mitigate all risks. The trust’s risk register is monitored quarterly by the trust executive committee to ensure risks are appropriately rated and should remain as a live risk.
4. Approach to financial planning

4.1 Control total 2016/17

The Royal Free’s annual plan for 2016/17 is a normalised surplus of £5.5m (before the profit on disposal). This is consistent with the control total calculated for the trust by NHS Improvement. Achievement of this control total is conditional upon a series of assumptions holding true. Any deviation to these assumptions will materially affect the ability of the trust to meet the agreed control total. The key assumptions are detailed from section 4.3, and summarised here:

- the trust meets the criteria for receipt of the sustainability and transformation funding allocation of £18.3m
- contract negotiations result in commissioner agreement to the assumptions applied to the clinical income forecast (discussed in more detail in section 4.3)
- the trust delivers the QIPP target of £46.3m
- agency expenditure is reduced to the target level of £29m

4.2 Recovery in 2015/16 financial position

The recovery in the 2015/16 financial position required to meet the control total in 2016/17 is set out in figure 1 which bridges the 2015/16 outturn normalised deficit of £21.2m to the 2016/17 control total of £5.5m. The key drivers of the improvement in financial position are as follows:

1. Sustainability and transformation funding of £18.3m (contingent on meeting performance and a series of financial criteria, yet to be defined)
2. CQUIN income of £16.8m
3. QIPP delivery of £46.3m (4.5%) which more than offsets inflationary cost pressures

4.3 Income

The clinical income forecast for 2016/17 is dependent on the conclusion of the 2016/17 contract negotiations with commissioners, as well as the terms of the national contract and the final national tariff. The following is a list of assumptions that underpin the clinical income forecast, and are considered to be outside the control of the trust.

1. CQUIN income is fully achieved at 2.5%. In light of national concern that the proposed CQUIN payments framework reduces the level of available CQUIN for many providers, this is considered a significant risk.
2. Local tariff uplift of 0.6%. This has been agreed by our lead commissioner (Barnet CCG) but other commissioners vary in their interpretation of the guidance.
3. Efficiency metrics will result in a £6m reduction in income, relating to efficiency measures expected to be included in the CCG contract. This has yet to be negotiated as part of the FY17 contract.
4. Income challenges raised by commissioners will be significantly below that seen in 2015/16 to date.
5. Contract penalties will not result in a loss of clinical income, in line with the legally binding BCF transaction agreement and NHS Improvement guidance.
6. PBR excluded drugs and devices – overhead recovery of 5% has been assumed on these drugs.

Contract negotiations for 2016/17 are proceeding with the NCL group of CCGs and with NHS England.

Non clinical income assumes the receipt of sustainability and transformation funding of £18.3m (as per the amount allocated to the trust); and Vanguard bid funding (offset by an equal cost, and therefore net neutral).

4.4 Costs
Employee expenses – forecast inflationary pressure in 2016/17 is £14.2m, of which £7.8m relates to ceasing the National Insurance contribution contracted out rebate. Pay awards and incremental drift make up the remainder of the inflationary cost pressure. The trust has forecast a reduction in annual agency spend from £42.9m in 15/16 to £28.3m in 16/17. This is within the agency cap communicated to the trust by NHSI. The workforce section details the plans in place to achieve this reduction.

Non pay expenses – forecast inflationary pressure in 2016/17 is £6.9m; of which the increase in clinical negligence premium is £2.4m. Another factor increasing non pay expenditure is the increase in tariff excluded costs relating to new drugs being used to treat hepatitis C, which is matched by pass through income.

4.5 QIPP and financial improvement

The trust’s financial improvement / transformation programme consists of a multi-year trust wide transformation programme aimed at improving value (quality and cost) across a variety of high priority areas.

Key areas for efficiency and productivity across the trust have been identified and these have been developed into multi year plans which will deliver over a period of 5 years, in line with the strategic direction set out for these service areas. The saving opportunities are based on initial standardisation of performance across sites followed by achieving top decile performance across all areas, and in later years delivering opportunities to improve efficiency across the health economy.

Due to the scale of the change required, which is likely to be more complex than previously experienced, greater governance around the QIPP Programme has been established. All large change programmes report into a change board which provides the forum for executives and divisional leads to have oversight of the programmes, understand delays and interdependencies and support implementation of mitigating actions.

The programmes cover a number of trust wide areas such as theatres, procurement, patient flow pharmacy and discharge, outpatients, non-clinical support services and workforce.

Embedding the Lord Carter recommendations into the programme

The Lord Carter recommendations have been mapped into existing programmes and have been used to inform priority areas of focus, the milestones for implementation and reporting are aligned to those set out within the review for example development of CHPPD is a core part of the nursing productivity programme. The trust has engaged with the Lord Carter process over the past year. The initial feedback and data has been used to support specialties in identifying opportunities for example trauma and orthopaedics now have a programme of work which picks up on a variety of elements of pay and non-pay productivity improvements including embedding the recommendations provided by Tim Briggs.

4.6 Outline of the programmes and how they have been aligned to the Lord Carter recommendations

We have a Financial Improvement Programme, based on Monitor best practice, which brings Carter, QIPP and a strengthened control environment together, and ensures that we have the core capabilities in the organisation to deliver in the challenging environment.

a. Workforce

The overarching objective of the workforce programme is to ensure that the trust has a stable and productive workforce that is clinically effective, ensures patient safety and service quality are its top priorities and has the clinical, managerial and leadership capability to improve the services delivered to our patients and deliver value for money.
The approach for the first year is to focus on getting the basics right. Some of this will be largely transactional – reduce spend on temporary staff, recruit, ensure processes are in place to support delivery. Over the longer term are the more fundamental changes to ways of working – introduction of new models of care and pan sector collaborations delivered by an appropriately skilled workforce.

There are six core workstreams which are recruitment process improvement, nurse recruitment and retention, nurse productivity, medical productivity, allied health professional productivity and new and extended roles. The table below outlines the high level scope of the workstreams and demonstrates how the Lord Carter recommendations have been embedded into the programme.

**Figure 2: Scope of workforce programme**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Scope</th>
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</thead>
<tbody>
<tr>
<td>Recruitment improvement</td>
<td>• Improvements in recruitment processes with a view to reducing the overall time to recruit</td>
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<tr>
<td></td>
<td>• Providing effective induction and on boarding for staff</td>
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<tr>
<td></td>
<td>• New ways of working</td>
</tr>
<tr>
<td>Nurse recruitment &amp; retention</td>
<td>• Implementing a rolling recruitment programme across all key areas</td>
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<tr>
<td></td>
<td>• Future direct employment scheme</td>
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<tr>
<td></td>
<td>• Overseas nurses programme</td>
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<tr>
<td></td>
<td>• Retention strategy for nursing</td>
</tr>
<tr>
<td>Nurse productivity</td>
<td>• E-rostering and safe care implementation (<em>Carter recommendations</em>)</td>
</tr>
<tr>
<td></td>
<td>• Management of enhanced care (<em>Carter recommendation</em>)</td>
</tr>
<tr>
<td></td>
<td>• Nurse productivity measure and implementation of CHPPD (<em>Carter recommendation</em>)</td>
</tr>
<tr>
<td></td>
<td>• Review of clinical nurse specialists</td>
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<tr>
<td></td>
<td>• Review of nursing shift patterns</td>
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<tr>
<td></td>
<td>• Nursing skill mix and development of new nursing roles</td>
</tr>
<tr>
<td>Medical productivity</td>
<td>• Job planning (<em>Carter recommendation</em>)</td>
</tr>
<tr>
<td></td>
<td>• Temporary staffing spend and additional sessions / WLIs</td>
</tr>
<tr>
<td></td>
<td>• Establishment of a substantive workforce that meets service needs (link to recruitment)</td>
</tr>
<tr>
<td></td>
<td>• Reducing variation in clinical practice and improving productivity</td>
</tr>
<tr>
<td></td>
<td>• Leadership and quality improvement</td>
</tr>
<tr>
<td></td>
<td>• New ways of working (link to New &amp; Extended roles workstream)</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>• Review of current operating model</td>
</tr>
<tr>
<td></td>
<td>• Recruitment and retention</td>
</tr>
<tr>
<td></td>
<td>• Development of a future model – link to new &amp; extended roles</td>
</tr>
<tr>
<td></td>
<td>• AHP training and development</td>
</tr>
<tr>
<td>New &amp; extended roles</td>
<td>• Oversee the development and implementation of a plan for the training of physician associates</td>
</tr>
<tr>
<td></td>
<td>• Plan and implement education and training supply routes for new and extended roles</td>
</tr>
</tbody>
</table>

b. Procurement

In line with Carter recommendations the focus of the procurement programme is on clinical standardisation of products to rationalise products used and secure the best value for money from existing suppliers and obtaining better prices from volume discounts through collaborative procurement practices and internal demand management. This will be driven by clearer policies and the improved control through increased utilisation of the approved electronic catalogue.

Delivery in the first two years is focused on establishing standardisation of products and practices across all Trust
sites especially in major areas such as orthopaedic implants and cardiology. This will be supported by engaging with both LPP and NHS SC to take advantage of opportunities and robust catalogue management. Supplier and contract reviews will be undertaken to establish that all KPIs are met and the Trust is contracted for the service level required. and getting value for money.

c. Pharmacy

The development of a pharmacy programme is underway, aligning with the recommendation set out by Lord Carter to have a hospital pharmacy transformation plan by April 2017, and be able to demonstrate how the targets will be achieved by 2020. Baseline data is being collated, for example % prescribing pharmacists, % patient facing time.

The programme will consider all elements of pharmacy service from the clinical services through to the support functions, and will consider the potential for further outsourcing as well as local, national and regional collaborative models to reduce costs and drive efficiency. This is especially relevant for procurement, manufacturing, dispensing, distribution, medicines information service and formulary functions.

4.7 Capital investment

The trust has developed an estates strategy which reflects clinical and strategic priorities. The strategy maintains a level of flexibility to ensure the estate is adaptable to changing clinical priorities. This prioritisation drives a multi-year capital programme that includes backlog maintenance, infrastructure improvements and service development.

The current strategic priority for the trust is to progress and rebuild Chase Farm Hospital, funded by a combination of land proceeds from the sale of surplus land at the site, PDC, debt, and depreciation. The backlog programme is prioritised using the core principles of Estatecode, taking information from our 6 facet survey and supplemented from data obtained through planned and reactive maintenance programme, as well as other regular condition assessments. All backlog is prioritised in accordance with the recommendations in Estatecode and our operational needs to ensure the investment is focused in the correct areas.

The capital programme is fully funded from internally generated funds (with the exception of the Chase Farm redevelopment which has agreed sources of external funding). The trust is considering alternative sources of capital financing, including options such as leasing, managed equipment services or outsourcing of certain services.

In the longer term, the trust is looking to make the most efficient use of its estate. There is an intention to consolidate clinical and research activity in the main hospitals sites, while relocating non clinical activities off site to free clinical expansion space.

4.8 Liquidity

Cash of £47m is forecast at the end of 2016/17. The key drivers in the improvement of the cash position during the year are collection of 15/16 outstanding commissioner debt; receipt of £18.3m transformation fund; and cash generation from operating activities. The key risk to the forecast cash position is collection of outstanding commissioner debt relating to 15/16 over performance. The trust has a £42m working capital facility in place, although a drawdown is not planned during the year.

4.9 Financial sustainability risk rating (FSRR)

An FSRR of 2 is forecast for the first 8 months of 2016/17, driven by the low I&E margin. The rating increases to 3 for the remainder of the year as the I&E margin improves in line with QIPP delivery.
5. Link to the emerging ‘Sustainability and Transformation Plan’ (STP)

The Royal Free has a close interest in three STPs, those for North Central London (NCL), Hertfordshire and North West London.

5.1 NCL STP

A PMO has been established to support the development of the STP and governance arrangements proposed. SROs from providers, CCGs and local authorities have been nominated and an NCL transformation board established to oversee the process. David Sloman is the overall lead for the NCL STP.

Carnall Farrar, who recently provided a report for CCGs identifying many of their strategic priorities, has been engaged to help the NCL organisations to develop their plan.

The established NCL finance group has begun to prepare a sector wider LTFM to help quantify the financial gap which the plan will need to address.

The content of the plan will depend on the leaderships of the organisations agreeing definitions of the problem, the strategy options and the agreed programmes to address the various gaps. The providers in the area have met and discussed what they believe the challenges that are facing them are, and provided feedback to the PMO for discussion and incorporation in the initial draft of the plan.

The Royal Free’s Vanguard programme has the potential to help address several of the major challenges faced by NCL and parts of the Hertfordshire STP area—such as excess demand, constrained capacity, variable clinical quality, unaffordable back office costs - and this will be developed in tandem with the NCL and Hertfordshire STPs.

5.2 Other STPs

The Hertfordshire STP is much further advanced thanks to deeply established county wide organisational relationships and acute services strategies that are either already implemented or agreed in principle by the major partners, although the addition of West Essex to this STP area will require some additional perspectives.

The NWL STP is likely to impact on both our demand management intentions and standardised pathways. Engagement over the coming months will help define our level of contribution to that plan.
6. Membership and elections

6.1 The council of governors

The council of governors comprises:
- 8 patient governors;
- 8 public governors (1 current vacancy);
- 6 staff governors; and
- 9 appointed governors (3 current vacancies).

The last governor elections took in September 2014 and March 2015. None is currently scheduled to take place until September 2017. Elections, and changes in appointed governors, have resulted in around half of the membership being relatively newly appointed and therefore there is an extensive continuing induction and development programme.

During the past year the internal auditors reviewed the governance procedures in place to support the council in fulfilling its responsibilities, including how well these have operated and whether they are in line with best practice. The auditors provided an assessment of ‘significant assurance (green)’. A number of areas of good practice were highlighted and the main areas for development included:
- governors’ role in member engagement;
- establishing greater clarity about the role of the lead governor; and
- the council’s perceived shortfall in its ability to hold NEDs to account.

These have all been incorporated into the council’s development programme.

6.2 Membership

Membership recruitment activity has been successful and at the time of submission there were over 24,600 members, comprising 10,256 public members, 4,420 patient members and 9,393 staff members. Staff members are automatically opted-in when they start working at the trust and can choose to opt-out at any time. Approximately 4,750 new patient and public members have joined since the acquisition of Barnet and Chase Farm hospitals in July 2014. Our membership continues to grow organically, mainly through the ‘pop up box’ on the trust website which provides a net increase of about 100 members monthly.

As the trust’s membership is considered to be well above the average, and recognising the trade-off between the quantity of members and the extent to which they can be effectively engaged, the main focus of attention in future will be on membership engagement together with the targeted recruitment of under represented groups.

In order to fulfil our role of making the trust truly locally accountable for the three broad communities that we mainly serve, we plan to improve engagement for local hospitals (Chase Farm, Barnet and Royal Free hospitals) by localising our engagement activities, for example site specific “medicine for members” talks, engagement material and events, governor authored pieces for publication across the trust’s communication channels, as well as ‘meet your governor’ sessions. Whilst in the past our engagement with members has tended to be one way, we are now exploring a range of initiatives to enable two way communication whereby members can if they wish become involved in making decisions about the trust’s current and future services.

Given that not all members want to be involved in membership activities, the trust is considering offering different levels of engagement in future, such as “gold, silver and bronze”, to give a choice of how much they wish to be involved. Asking what members are interested in on sign-up will allow for a more cost effective engagement. Moving from simply informing members to having their participation and collaboration is the desired outcome of the engagement process.